Comprehensive State Plan

2002-2008

Virginia
Department of Mental Health, Mental Retardation
and Substance Abuse Services

November 30, 2001

Comprehensive State Plan
2002-2008
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Comprehensive State Plan 2002-2008
Executive Summary

The Comprehensive State Plan 2002-2008 fulfills the requirement in §37.1-48.1 of the *Code of Virginia* to produce a six-year plan for mental health, mental retardation, and substance abuse services. By statute, the Comprehensive State Plan must identify the services and supports needs of persons with mental illnesses, mental retardation, or alcohol or other drug dependence or abuse problems across the Commonwealth; define resource requirements; and propose strategies to address these needs.

Mission: The Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) is committed to improving the quality of life and self-sufficiency of people with serious mental illnesses, serious emotional disturbances, mental retardation, developmental delays, and alcohol and other drug dependence (addiction) or abuse problems and to preventing, to the greatest extent possible, the devastating personal, social, and economic consequences of mental disabilities and addictions to or abuse of alcohol and other drugs. The Department accomplishes this mission by providing for high quality, home and community-centered, and outcome-oriented services at a reasonable cost. This is achieved through a coordinated and managed system of care that respects and promotes the dignity, rights, and full participation of individuals who need services and their families.

Values and Principles Influencing the Services System: In *Building Virginia's Future A Time for All Virginians: A Strategic Plan for the Commonwealth of Virginia*, 1999, Governor Gilmore articulated his vision and goals for the Commonwealth. The goals for health and human resources are to deliver high-quality health and human services for Virginians, foster programs that engender personal responsibility, and promote policies that strengthen families, preventing a downward spiral toward government dependency.

The goals of the Governor's *Five Point Plan for the Future of Mental Health in Virginia* are to improve the quality of care and conditions at Virginia's state mental health and mental retardation facilities and to strengthen community-based resources for care and treatment of individuals with mental disabilities.

Values and principles of the Health and Human Resources Secretariat include: market-oriented and more flexible government, greater emphasis on citizen involvement, increased coordination and collaboration among state agencies, greater focus on program outcomes and improvements in quality of care, promotion of performance improvement and professional integrity, and emphasis on boosting independence and self-sufficiency of individuals.

Services System Characteristics and Trends: Title 37.1 of the *Code of Virginia* establishes the Department as the state authority for alcoholism, drug abuse, mental health, and mental retardation services. As the state authority, the Department assures that efficient, accountable, and effective services are available for citizens with the most serious mental disabilities.

By statute, the State Mental Health, Mental Retardation and Substance Abuse Services Board offers policy direction for Virginia's services system. The Department's Central Office provides system leadership, direction, and accountability through a variety of functions, including policy interpretation and

implementation, strategic planning, licensing, human rights, technical guidance, operational oversight and monitoring, funding, performance contracting, risk management and quality assurance, research and evaluation, and staff development and training.

Virginia's publicly-supported services system includes 15 state facilities and 40 community services boards (CSBs). Community services boards are established by local governments and are responsible for delivering community-based mental health, mental retardation, and substance abuse services, either directly or through contracts with private providers. They are the single point of responsibility and authority for assessing consumer needs, accessing a comprehensive array of services and supports, and managing state-controlled funds for community-based services.

- In FY 2000, 118,210 persons received mental health services; 22,036 individuals received mental retardation services; and 61,361 people received substance abuse services provided through CSBs. These are unduplicated numbers of consumers.
- Between FY 1986 and FY 2000, the number of people receiving various CSB services grew from 208,453 to 295,227, a 42 percent increase. This is not an unduplicated count because many individuals receive more than one service.
- Between FY 1986 and FY 2000, total CSB resources increased from $147.5 million to $525 million (not including Medicaid MR Waiver payments to private providers), a 257 percent increase.

State mental health and mental retardation facilities provide highly-structured intensive inpatient treatment and habilitation services. State mental health facilities provide a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided for geriatric, child and adolescent, and forensic patients. Mental retardation training centers provide residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development. The Hiram Davis Medical Center provides medical care to state facility patients and residents. Current operating bed capacities are 1,883 for state mental health facilities and 1,706 for mental retardation training centers.

- Since FY1996, the average daily census at the state mental health facilities declined by 581 or 26 percent (from 2,222 to 1,641), the number of admissions declined by 2,245 or 30 percent (from 7,468 to 5,223) and the number of separations declined by 2,353 or 31 percent (from 7,529 to 5,176).
- Since FY 1996, the average daily census at the state mental retardation training centers declined by 451 or 21 percent (from 2,131 to 1,680).

Between FY 1986 and FY 2001, total state mental health and mental retardation facility resources increased from $263,641,832 to $473,462,300, an 80 percent increase.

FY 2000 funding for Virginia's publicly-funded services system from all sources (rounded and in millions), including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid MR Waiver payments to private vendors totaled $1.106.4 billion, of which $602.4 million (54.4 percent) was allocated to CSBs, $461.9 million (41.7 percent) was allocated to state mental health and mental retardation facilities, and $42.1 million (3.8 percent) was allocated to the Department's Central Office.

Estimated Prevalence: The Comprehensive State Plan for 2002-2008 applies prevalence rates from national epidemiological studies to Virginia 2000 Census data to extrapolate the estimated prevalence in Virginia for adults with serious mental illness, children and adolescents with or at risk of serious emotional disturbances, individuals with mental retardation, and individuals with substance dependence or abuse.

- Approximately 233,189 Virginia adults are estimated to have had a serious mental illness at any time during the past year.
- Between 79,687 and 97,395 Virginia children and adolescents are estimated to have a serious emotional disturbance. Between 44,271 and 61,979 of these children and adolescents exhibit extreme impairment.
- Between 26-191 and 41,763 Virginians are estimated to have mild mental retardation, 14,157 have moderate mental retardation, 9,202 have severe mental retardation; and 2,831 have profound mental retardation.
- Approximately 97,943 Virginia adults and adolescents (age ten and older) are estimated to have drug dependence and 226,494 are estimated to have alcohol dependence.

In reviewing these estimated prevalence rates, it is important to recognize that only a portion of individuals with diagnosable disorders will need to receive services at any given time and an even smaller portion will require or seek services from the public sector.

Documented Unmet Service Demand: To document current demand for community mental health, mental retardation, and substance abuse services, CSBs used a waiting list data base to provide specific information about each individual whom they determined needed but was not currently receiving community services. The following table displays counts of individuals on CSB waiting lists as of April 2, 2001. This point-in-time methodology for documenting unmet service demand represents a conservative count because it does not identify the number of persons in need of services over the course of a year. Nor does it include individuals whose service needs are not known to and assessed by the CSBs.

Numbers of Individuals on CSB Waiting Lists for Services by Population

April 2, 2001

Population	Numbers on CSB Waiting Lists Who Are NOT Receiving CSB Services	Numbers on CSB Waiting Lists Who ARE Receiving Some CSB Services	Total Numbers on CSB Waiting Lists
Adults with Serious Mental Illnesses	593	3,865	4,458
Children & Adolescents with or At Risk of Serious Emotional Disturbance	312	1,037	1,349
Individuals with Mental Retardation	892	3,324	4,216
Adults with Substance Dependence or Abuse	585	1,601	2,186
Adolescents with Substance Dependence or Abuse	65	280	345
Total	2,447	10,107	12,554

For this Comprehensive State Plan, an individualized state facility discharge data base was created to identify, on a quarterly basis:

- patients in state mental health facilities who have been determined to be ready for discharge if community services were available, and
- training center residents for whom there was agreement by the resident or his legally authorized representative to be discharged to community services and supports.

The following tables display the number of patients determined to be ready for discharge from state mental health facilities and the number of residents identified as choosing to be discharged from training centers.

Number of Patients in Mental Health Facilities Identified as Ready for Discharge by Facility

June 30, 2001

State Mental Health Facility	Patients	State Mental Health Facility	Patients
Catawba Hospital	29	Piedmont Geriatric Hospital	17
Central State Hospital	24	Southern Virginia MH Institute	10
Commonwealth Center for Child. & Ad.	0	Southwestern Virginia MH Institute	4
Eastern State Hospital	30	Western State Hospital	5
Northern Virginia MH Institute	18	Total	137

Number of Residents in Mental Retardation Training Centers Identified as Choosing Discharge

June 30, 2001

Training Center	Residents	Training Center	Residents
Central Virginia Training Center	130	Southside Virginia Training Center	25
Northern Virginia Training Center	15	Southwestern Virginia Training Center	5
Southeastern Virginia Training Center	81	Total	256

Goals and Future Directions for the Services System: The Comprehensive State Plan for 2002-2008 proposes a number of actions to enhance and improve Virginia's current services system, including the following goals, objectives and strategies.

- *Access to Care:* Expand access to a full range of community-based mental health, mental retardation, and substance abuse services by:
  - addressing current service demand;
  - developing targeted treatment and prevention services; and
  - addressing access issues of specific populations, including
    - older adults,
    - children and youth,
    - persons with dual diagnoses of mental illness and mental retardation,
    - persons requiring opioid treatment,
    - persons involved with the criminal justice system, and
    - persons who are deaf, hard-of-hearing, late deafened, or deafblind.

- *Continuity of State Facility and Community-Based Care:* Promote and facilitate continuity of state facility and community-based care by:
  - improving and standardizing preadmission screening practices,
  - expanding and enhancing diversion projects, and
  - implementing uniform discharge planning protocols and practices and standardized discharge plan data across all CSBs and with all state facilities,
  - resolving systemic barriers to discharge, and
  - providing individualized services for state mental health facility patients who have been identified as clinically ready for discharge and state training center residents who have chosen community services and supports instead of continued training center placement.
- *Consumer and Family Involvement, Education, and Training:* Enhance consumer and family involvement in all aspects of Virginia's services system by:
  - providing opportunities for consumers and families to voice concerns and resolve issues;
  - developing consumer and family education and training regarding their illnesses and treatments;
  - facilitating consumer and family involvement in state and local policy making and operational activities;
  - linking consumers and families to available resources; and
  - promoting substance abuse consumer advocacy.
- *Service Quality, Responsiveness, and Effectiveness:* Improve service quality, responsiveness, and effectiveness across Virginia's services system by;
  - protecting the individual human rights of individuals receiving mental health, mental retardation, and substance abuse services in state facilities and community programs;
  - complying with state facility active treatment and habilitation clinical care expectations and uniform clinical guidelines;
  - promoting implementation of evidence-based clinical practices in state facilities and CSBs;
  - enhancing medications management;
  - implementing a systemic, organization-wide approach to quality improvement through the Performance and Outcomes Measurement System (POMS), the Department's Quality Council, and peer review activities; and
  - providing oversight and monitoring of state facility operations, potential risks and liabilities, CSB performance requirements, human rights protections, and licensing requirements.
- *Human Resources Management and Development:* Implement a systemic and integrated response to critical workforce management and human resources development issues facing the services system by:
  - developing methodologies for forecasting future workforce demand for specific positions;
  - recruiting difficult-to-fill positions;
  - retaining services system employees in competitive markets;

- promoting the cultural competence of workforce employees;
- matching employee skills and appropriate professional practice guidelines to clinical services needs;
- creating opportunities for workforce training, professional growth, and staff development; and
- developing an early intervention workforce that meets practice guidelines.

- *Care Utilization Management to Assure Appropriateness of Services:* Implement care utilization management technologies and practices to:
  - assure the appropriateness of services provided to specific individuals;
  - promote positive outcomes;
  - assure adherence to professionally-recognized clinical practices; and
  - achieve market-based efficiencies in service delivery and management through inpatient psychiatric services utilization management, management of targeted community funding pools, and Medicaid MR Waiver preauthorization.
- *System Design and Integration:* Enhance services system integration by:
  - promoting provider development;
  - improving understanding of conditions affecting private provider participation in the publicly-funded services system;
  - enhancing the critical care coordination functions of CSBs;
  - providing appropriate oversight of services not funded by the Department;
  - improving relationships with other agencies and systems providing services and supports to individuals with mental disabilities or substance abuse or dependence, especially in areas such as Medicaid, social services, housing, primary health care, and vocational assistance; and
  - supporting the Department's linkage with local governments and the CSBs.
- *System Administration:* Respond to system administration requirements by:
  - achieving compliance with the Health Insurance Portability and Accountability Act (HIPAA) and new federal block grant requirements;
  - improving the service system's use of information technologies;
  - standardizing, streamlining, and integrating information reporting requirements; and
  - addressing state facility infrastructure requirements and capital outlay improvements.

Resource Requirements: The Comprehensive State Plan 2002-2008 has identified responses to the critical issues facing Virginia's services system. The following table summarizes 2002-2004 biennium total resource requirements, including non-general funds, identified by the Department:

Proposed Initiative or Request	**FY 2003** SGF	NGF	**FY 2004** SGF	NGF	**Biennium Total** SGF	NGF
Enhance MR Training Center Staffing	4,609,696	4,858,001	6,921,467	7294,296	11,531,163	1,215,297
Discharge 70 State MH Facility Patients	4,956,000		4,956,000		9,912,000	

Proposed Initiative or Request	FY 2003 SGF	FY 2003 NGF	FY 2004 SGF	FY 2004 NGF	Biennium Total SGF	Biennium Total NGF
Discharge 100 MR Training Center Residents*	3,552,000	3,696,980	3,552,000	3,696,980	7,104,000	7,393,960
Enhance Region IV Acute Care Project	500,000		500,000		1,000,000	
Enhance DAD Project	105,545		216,050		321,595	
Fund Community MH Services to Address CSB Waiting Lists	4,727,000	1,760,693 **	9,454,000	3,521,386 **	14,181,000	5,282,079 **
Fund Community SA Services to Address CSB Waiting Lists	1,872,450	280,590 **	3,744,900	651,180 **	5,617,350	841,770 **
Develop a Secure Primary SA Diversion Program	1,000,000		560,000		1,560,000	
Fund Community MR Services For Non-Waiver Eligible Individuals on CSB Waiting Lists	3,617,675	1,256,909 **	7,235,350	2,513,818 **	10,853,025	3,770,727
Provide Start-Up Funds for MR Waiver Services	800,000		600,000		1,400,000	
Provide MH, MR, and SA Case Management Services	1,175,461	342,192 **	2,350,922	648,384 **	3,526,383	990,576 **
Expand Community Psychiatric Services	1,500,000	300,000 **	1,500,000	300,000 **	3,000,000	600,000 **
Add Two PACT Teams	1,400,000		1,400,000		2,800,000	
Establish Prevention Programs	1,500,000		1,500,000		3,000,000	
Expand Access in CSBs to Atypical Medications	3,700,000		3,700,000		7,400,000	
Replicate NVTC Center for Excellence at Four Training Centers	1,800,000		1,400,000		3,200,000	
Implement Southern Virginia Regional Community Capacity Initiative	6,010,000		4,625,000		10,635,000	
Implement Eastern Virginia Regional Community Capacity Initiative	8,299,302	1,229,270 **	8,299,302	1,229,270 **	16,598,604	2,458,540 **
Implement Crisis Stabilization Programs in Regions IV and I	1,443,174		1,111,200		2,554,374	
Provide Targeted MH and SA Services in Jails and Juvenile Detention Centers	1,471,832		1,471,832		2,943,664	

Proposed Initiative or Request	FY 2003 SGF	FY 2003 NGF	FY 2004 SGF	FY 2004 NGF	Biennium Total SGF	Biennium Total NGF
Create a Secure Juvenile MH Treatment Program	6,903,952		1,840,051		8,744,003	
Increase the Number of Human Rights Advocates	340,000		680,000		1,020,000	
Increase the Number of Licensing Specialists	245,450		225,450		470,900	
Achieve Compliance with HIPAA	3,410,004		1,288,004		4,698,008	
Implement a Sexually Violent Predators Program	9,945,149		4,899,049		14,844,198	
Address Increased State Facility Energy Costs	2,000,000		2,000,000		4,000,000	
Fund Phase Two FMS II Implementation	217,375		161,775		379,150	
Address General Fund Medicaid Match Shortfall	13,700,000		13,700,000		27,400,000	
Address Existing ESH Budget Shortfall	1,200,000		1,200,000		2,400,000	
TOTAL	$92,002,065	$13,724,635	$91,092,352	$19,855,314	$183,094,417	$22,552,949

Notes:

* These funds would be appropriated to the Department of Medical Assistance Services.

** Non-general funds include anticipated Medicaid and third party payer fees, direct client fees, and other revenues for community services.

Terrorism-Related Service and Infrastructure Requirements: With the September 11th terrorist attack and subsequent events, the current missions of state mental health authorities and CSBs have been challenged. Along with maintaining traditional responsibilities for serving adults with the most serious mental illnesses and youth with serious emotional disturbance, state and local mental health providers are finding themselves called upon to provide outreach and targeted interventions to persons in the general public who are experiencing fears, anxieties, and depression arising from the recent terrorism events.

The Comprehensive State Plan 2002-2008 summarizes the Department's recent assessment of the terrorism-related mental health and substance abuse service needs in Virginia. This assessment includes a description of mental health and substance abuse interventions by 72 community and mental health organizations in the Northern Virginia region since the September 11th terrorist attacks. The Northern Virginia CSBs estimate that 35,776 residents in the areas they serve may need mental health or substance abuse services as a result of the September 11th terrorist attacks and subsequent bio-terrorist threats and events.

The Plan describes specific recommendations for service system enhancements at both the state and local levels to:

- Enable Virginia's mental health, mental retardation, and substance abuse services system to better

understand and prepare for the heightened threat potential facing the Commonwealth, and

- Establish structures and relationships that will assure an immediate, effective, and coordinated response to terrorism-related and other major disasters.

Recommended enhancements include the development and implementation of Special Psychiatric Immediate Response, Intervention, and Treatment (SPIRIT) Teams. SPIRIT teams would provide a regional structure to prepare for, organize, and activate an immediate psychiatric response for first responders and victims of catastrophic events.

Because the magnitude and duration of this event is unprecedented, it is almost impossible to accurately predict the future mental health and substance abuse service needs that will result from the terrorist attacks of September 11th and subsequent bio-terrorist threats and actions. The Plan identifies a number of specific service and infrastructure requirements totaling $53,835,758 for Virginia's publicly-funded services system. An effective and appropriate response to these needs and new responsibilities should be supported financially by the federal government as part of its national defense responsibilities to combat and respond to terrorism.

Conclusion: The directions established in the Comprehensive State Plan 2002-2008 would enable the Commonwealth to accelerate the shift to a more community-based system while preserving the important roles and service responsibilities of state mental health and mental retardation facilities in Virginia's public services system. A delicate balance has been achieved between state facility and community services. On the state facility side, this balance is based on smaller community demand for state hospital inpatient psychiatric services, reduced state facility average daily censuses, improved quality of state facility care, and slightly larger appropriations. On the community side, this balance is based on greatly increased appropriations, expanded targeted services, diversions of inappropriate state facility admissions, and more use of private sector inpatient psychiatric beds. This balance is founded on current policy directions, economics in the public and private sectors, and the need to:

- Maintain quality and protect services in state facilities in order to avoid greater costs from future court consent decrees or Olmstead-related decisions;
- Sustain the capacity of CSBs; and
- Continue support and development of targeted services.

While the past four years have been characterized by broad-based growth and expansion in an extremely favorable economic climate, that climate is changing dramatically as a result of the deceleration of the economy that began this summer and has continued in the aftermath of the tragic events of September 11th. To the extent possible, the policy agenda for publicly-funded mental health, mental retardation, and substance abuse services for the next biennium needs to focus on two key themes:

- Sustainability of the progress that has been achieved, especially for consumers and family members who have benefited from the expansion and improvement of services during the past four years; and
- Clearly focused growth and development efforts to address, to the extent possible, the critical issues facing Virginia's mental health, mental retardation, and substance abuse services system.

The *Comprehensive State Plan for 2002-2008* continues the direction set forth in the *2000-2006 Comprehensive State Plan* to change an essentially open-ended services system into one that targets resources to those who need services the most and to increase community options and consumer choice; supports opportunities for consumer and family member education, training and participation; promotes collaborative activities with other agencies and services systems and private sector development; improves services oversight and accountability; advances quality improvement and care coordination; and addresses system administrative and infrastructure issues.

Comprehensive State Plan
2002 - 2008

I. Introduction

In 1998, the *Code of Virginia* was amended to add §37.1-48.1, which requires the Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) to develop and update biennially a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services. This plan must identify the services and supports needs of persons with mental illnesses, mental retardation, or alcohol or other drug dependence or abuse problems across Virginia; define resource requirements; and propose strategies to address these needs. That *Code* section also requires that the plan be used in the preparation of the Department's biennium budget submission to the Governor.

The initial Comprehensive State Plan for 1985-1990 proposed a "responsible transition" to a community-based system of services. In 1986, the plan was expanded to cover a six-year time frame, with updates corresponding to the Department's biennium budget submissions. These updates continued until 1995, when agency strategic planning efforts replaced the 1996-2002 plan update. Biennial updates were reinstated in 1997 with the 1998-2004 Comprehensive State Plan. The 2000-2006 Comprehensive State Plan introduced an individualized waiting list data base to document service requirements and characteristics of individuals on community services board (CSB) waiting lists.

Over the years, the Department's Comprehensive State Plan has evolved to serve a number of purposes. The plan:

- establishes services system priorities and future system directions for the public mental health, mental retardation, and substance abuse services system;
- describes strategic responses to major issues facing the services system;
- identifies priority service needs;
- defines resource requirements and proposed initiatives to respond to these requirements; and
- helps to integrate the agency's strategic and budget planning activities.

For the 2002-2008 Comprehensive State Plan, the Department created two individualized data bases – a point-in-time survey of CSB waiting list data base and a quarterly survey of patients in state mental health facilities identified as ready for discharge if community services were available and of training center residents for whom there was agreement by the resident or his legally authorized representative to be discharged to community services and supports. The CSB data base provided the following information for active consumers and others receiving no services who had been assessed, as of April 2, 2001, as needing specific services and supports:

- demographic current service status, including priority population status, and current type of residence information;
- a determination by the CSB of specific service needs; and
- an assessment of risk factors.

This survey was not intended to account for "overall community unmet need." Rather, its purpose was to provide a conservative count of individuals who were known to the CSB to require certain services that were appropriate for their specific needs. Following CSB submission of this information in early June 2001, Department staff reviewed and questioned unusual patterns of needed services and worked with CSBs to resolve any data anomalies.

The state facility discharge data base requested that CSBs and state facilities collaborate to provide the following information on a quarterly basis:

- demographic information on state facility patients and residents on facility discharge lists;
- community service availability or lack of availability due to resource or provider issues; and
- documented discharge barriers.

For this Plan, the Department used data for the quarter ending June 30, 2001. This data was reconciled with state facility data provided to the CSB for accuracy.

For this plan, the Department also asked the CSBs to project service wait times and identify prevention service priorities that respond to adolescent problem behaviors and risk factors for adolescent substance use, violence, delinquency, suicide, and sexual behavior.

In August 2000, the Department established a Comprehensive State Plan Focus Group representing CSBs, state facilities, private providers, consumer and advocacy organizations, other state agencies, and local governments. This focus group met several times with the Department's Office of Planning and Development staff during the fall of 2000 and in the summer of 2001 to assist in the identification of data elements to be included in both data bases and to identify major issues facing the services system.

In addition, Office of Planning and Development staff met with an ad hoc CBS Waiting List Work Group a number of times throughout the plan development process, first to assist in the development of the waiting list data bases and then to review and provide feedback regarding the data submitted by the CSBs. This work group included CSB executive directors; mental health, mental retardation, and substance abuse program directors; quality assurance directors; and information technology directors.

The draft 2002-2008 Comprehensive State Plan was distributed for public review and comment in early October 2001. The State Mental Health, Mental Retardation and Substance Abuse Services Board scheduled five regional public hearings to receive comments of the draft plan during the week of October 22, 2001. Department staff also convened the Comprehensive State Plan Focus Group to review and discuss the issues and strategic directions in the draft plan.

II. Services System Mission, Structure, and Organization

MISSION

The Department is committed to improving the quality of life and self-sufficiency of people with serious mental illnesses, serious emotional disturbances, mental retardation, developmental delays, and alcohol and other drug dependence (addiction) or abuse problems and to preventing, to the greatest extent possible, the devastating personal, social, and economic consequences of mental disabilities and addictions to or abuse of alcohol and other drugs.

The Department accomplishes this mission by providing for high quality, home and community-centered, and outcome-oriented services at a reasonable cost. This is achieved through a coordinated and managed system of care that respects and promotes the dignity, rights, and full participation of individuals who need services and their families.

SERVICE SYSTEM VALUES AND PRIORITIES

Governor's Strategic Plan

In *Building Virginia's Future A Time for All Virginians: A Strategic Plan for the Commonwealth of Virginia*, 1999, Governor Gilmore articulated his vision and goals for the Commonwealth. The goals for health and human resources are to deliver high-quality health and human services for Virginians, foster programs that engender personal responsibility, and promote policies that strengthen families, preventing a downward spiral toward government dependency. The first objective and associated strategies to achieve these goals addresses the public mental health, mental retardation, and substance abuse services system.

- Build a responsive delivery system of high-quality mental health, mental retardation, and substance abuse services for Virginians.
    - Ensure Virginia's public mental health and mental retardation facilities comply with the Civil Rights of Institutionalized Persons Act (CRIPA).
    - Appoint an Inspector General to ensure continual quality improvement in care at Virginia's mental health and mental retardation facilities.
    - Develop policies and strategies to assess and place mental health and mental retardation patients in state facilities into appropriate settings for care.

This strategic plan affirms that Virginians with mental illness, mental retardation, or substance abuse problems deserve high-quality treatment and services in the most appropriate setting. It further states that in order to balance limited resources with the level of need, the state must assess patients and provide them with care that is both cost effective and appropriate. The state must continually evaluate program delivery and determine if those programs provide the outcomes they promised. Programs not performing as expected should be modified accordingly.

The goals of the Governor's *Five Point Plan for the Future of Mental Health in Virginia* are to improve the quality of care and conditions at Virginia's state mental health and mental retardation facilities and to strengthen community-based resources for care and treatment of individuals with mental disabilities. Specific objectives in this plan include:

- the appointment of an Inspector General to monitor systemic changes in the quality of care provided in state mental health and mental retardation facilities;
- increased attention to human rights protections by strengthening the Department for the Rights of Virginians with Disabilities and improving the internal human rights program of the Department of Mental Health, Mental Retardation and Substance Abuse Services;
- improvements in the quality of care through increased availability of newer anti-psychotic medications and efforts to take full advantage of the new treatments that medical advances have made available;
- expansion of community-based resources to make sure community options are widely

available; and

- personal inspections of each state facility by Administration officials.

Health and Human Resources Priorities

Values and principles articulated by the Office of the Secretary of Health and Human Resources follow.

- *Government:* Increase flexibility for and place fewer restraints on local government.
- *Market-oriented government:* Inject competition in service delivery and promote market-oriented solutions where appropriate to contain costs, encourage competition, and foster innovation.
- *Consumer-oriented government:* Provide greater citizen involvement and target interventions that are the least intrusive when necessary.
- *Efficiency-oriented government:* Increase coordination and collaboration among state agencies.
- *Accountable government:* Promote performance improvement and professional integrity.
- *Results-oriented government:* Provide a greater focus on program outcomes for taxpayers and improve the quality of care through continual quality improvement.
- *Prevention-oriented government:* Use foresight to solve problems before they arise. Boost the independence and self-sufficiency of individuals and discourage dependency and entitlement by fostering mediating structures such as neighborhood, churches, voluntary associations, and community involvement as well as strengthening the family and championing prevention strategies that encourage personal responsibility.

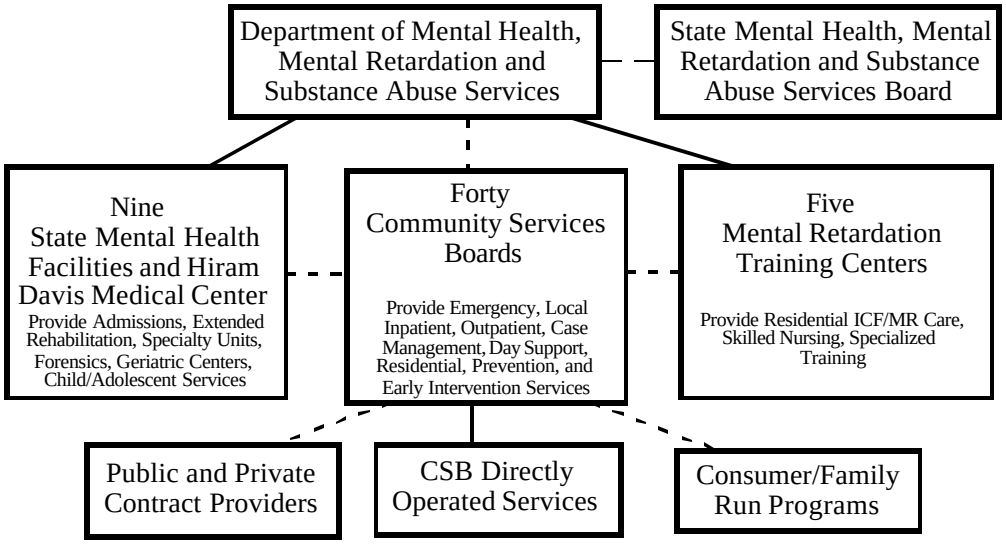
STATUTORY RESPONSIBILITY

Title 37.1 of the *Code of Virginia* establishes the Department of Mental Health, Mental Retardation and Substance Abuse Services as the state authority for alcoholism, drug abuse, mental health, and mental retardation services. As the state authority, the Department assures that efficient, accountable, and effective services are available for citizens with the most serious mental disabilities.

By statute, the State Mental Health, Mental Retardation and Substance Abuse Services Board offers policy direction for Virginia's services system. The Department's Central Office provides system leadership, direction, and accountability through a variety of functions, including policy interpretation and implementation, strategic planning, licensing, human rights, technical guidance, operational oversight and monitoring, funding, performance contracting, risk management and quality assurance, research and evaluation, and staff development and training.

Virginia's publicly-supported services system includes 15 state mental health and mental retardation facilities and 40 community services boards (CSBs). Maps of CSB service areas and the locations of state facilities are provided in Appendix A. The diagram on the following page outlines the current relationships between these services system components. Direct operational relationships are shown by solid lines between the involved entities (e.g., the Department operates the state mental health and mental retardation facilities). Non-operational relationships (e.g., policy direction, contracting, or service coordination) are reflected by broken lines.

Graphic Representation of Virginia's Public Mental Health, Mental Retardation, and Substance Abuse Service System



CHARACTERISTICS OF COMMUNITY SERVICES BOARDS

Community mental health, mental retardation, and substance abuse services are provided in Virginia by community services boards (CSBs), behavioral health authorities (BHAs), or local government departments (LGDs) with policy-advisory CSBs. These organizations, which are generally called CSBs, function as:

- the single point of entry into the publicly-funded mental health, mental retardation, and substance abuse services system, including providing access to needed state facility services through preadmission screening, case management, and coordination of services, and predischarge planning for individuals leaving state facilities;
- service providers, directly and through contracts with other providers;
- advocates for consumers and individuals in need of services;
- community educators, organizers and planners;
- advisors to the local governments that established them; and
- the primary locus of programmatic and financial accountability.

Section 37.1-194.1 of the *Code of Virginia* defines three types of CSBs: operating CSBs, administrative policy CSBs, and policy-advisory CSBs with a local government department. In addition, BHAs, established pursuant to the provisions of Chapter 15 in Title 37.1 of the *Code*, may deliver community mental health, mental retardation, and substance abuse services.

CSBs are not part of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. The Department's relationships with all CSBs are based on the community services performance contract. The Department funds, monitors, licenses, regulates, and provides consultation to CSBs.

CSBs exhibit tremendous variety in almost all aspects of their composition, organizational structure, and services. This diversity is evident in the following tables.

Combined Classification of Community Services Boards

CSB Classification	Functions as LGD	Cities and/or Counties Served		Total CSBs
		One	Two or More	
Administrative Policy CSBs	7	6	1	7
Administrative Policy CSB[1]	0	1	2	3
LGD with Policy-Advisory CSB	1	1		1
Operating CSB[2]	0	2	26	28
Behavioral Health Authority[2]	0	1		1
TOTAL CSB	8	11	29	40

[1] Even though these CSBs are not city or county departments, they use local government employees to staff the CSB and deliver services

[2] Staff in these 28 CSBs and one BHA are board, rather than local government employees.

More than 9,800 staff work in directly-operated programs at the 40 CSBs.

Combined Characteristics of Community Services Boards FY 2000

Budget Size, Population Density, and Population Size	Operating CSBs	Administrative Policy CSBs	Total CSBs
Large Budget, Urban, Large Population	3 CSBs	4 CSBs	7
Large Budget, Urban, Medium Population	1 CSB, 1 BHA	2 CSBs	4
Medium Budget, Urban, Large Population	1 CSB	1 CSB	2
Medium Budget, Urban, Medium Population	1 CSB	2 CSBs, 1 LGD	4
Medium Budget, Rural, Large Population	1 CSB		1
Medium Budget, Rural, Medium Population	10 CSBs		10
Medium Budget, Rural, Small Population	1 CSB		1
Small Budget, Urban, Small Population		1 CSB	1
Small Budget, Rural, Medium Population	2 CSBs		2
Small Budget, Rural, Small Population	8 CSBs		8
Total CSBs	29	11	40

Budget Size Based on FY 2000 4th Quarter Performance Contract Reports: Large = over $15 million; Medium = $8 million to $15 million; Small = under $8 million
Population Density: Urban = 150 people or more per square mile; Rural = less than 150 people per square mile. Population statistics are based on the 2000 U.S. Census
Population Size: Large = over 200,000; Medium = 100,000 to 200,000; Small = under 100,000.

In FY 2000, 201,607 individuals received services. This total is broken down by program area in the following table. Core Services Taxonomy 6 defines services (see Appendix B).

Numbers of People Receiving Core Services by CSB in FY 2000

Core Service	MH	MR	SA	Total
Emergency	47,881	10	9,337	57,228
Local Inpatient	1,554	NA	147	1,701
Outpatient	80,860	144	45,793	126,797
Case Management	37,510	10,701	13,660	61,871
Day Support	7,697	4,643	2,187	14,527
Residential	4,483	4,050	12,936	21,469
Early Intervention	798	6,538	4,298	11,634
Total Receiving Core Services	180,783	26,086	88,358	295,227
Unduplicated Numbers of Consumers	118,210	22,036	61,361	201,607

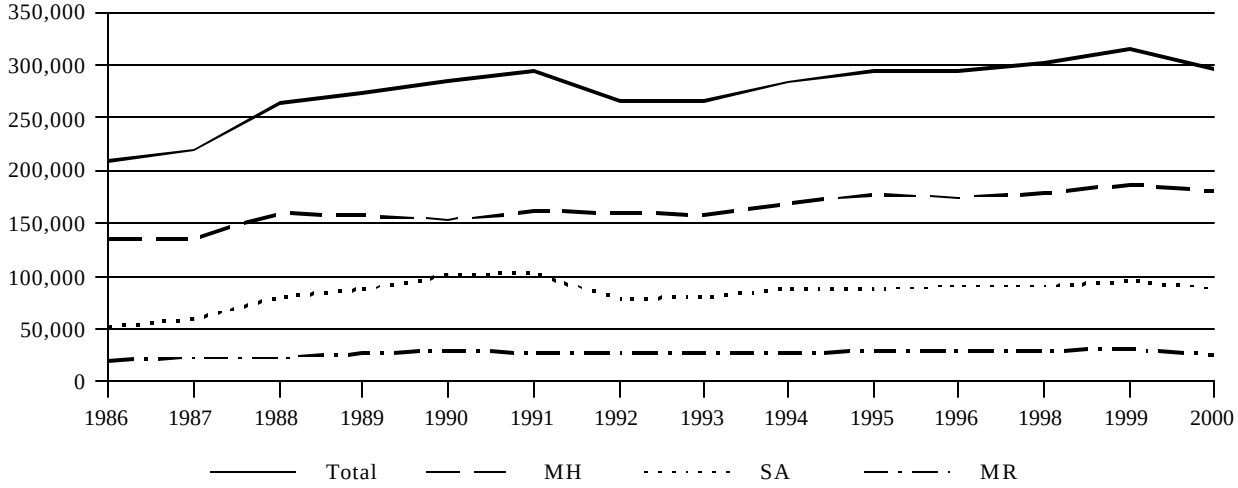
Source: FY 2000 CSB 4th Quarter Performance Reports

Note: Total consumers receiving core services represent duplicated counts since some people receive multiple services. Unduplicated numbers of consumers are all individuals receiving any services in each program area. NA = not applicable (service not provided).

Between FY 1986 (the first year that annual performance contract data was submitted by CSBs) and FY 2000, the numbers of people receiving various CSB services grew from 208,453 to 295,227, an increase of 42 percent. From FY 1986 to FY 2000, total CSB resources increased from $147 million to more than $525 million (not including Medicaid MR Waiver payments to private providers), a 257 percent increase. Trends in the numbers of individuals receiving mental health, mental retardation, and substance abuse services from CSBs are displayed on the following graph.

Trends in Numbers of Individuals Served by CSBs

FY 1986 - FY 2000



These numbers are duplicated counts of individuals receiving services because they are derived from fourth quarter CSB reports that display numbers of people receiving services by core service categories. Appendix B provides detailed FY 2000 CSB information, including units of services provided, static capacities, and consumers served, as well as service trends.

CHARACTERISTICS OF STATE MENTAL HEALTH AND MENTAL RETARDATION FACILITIES

The Department operates 15 state mental health or mental retardation facilities, which provide highly-structured intensive inpatient treatment and habilitation services. State mental health facilities provide a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary services. Specialized programs are provided for geriatric, child and adolescent, and forensic patients. Mental retardation training centers provide residential care and training in areas such as language, self-care, independent living, socialization, academic skills, and motor development. The Hiram Davis Medical Center provides medical care to state facility patients and residents.

All state mental health facilities are accredited by the Joint Commission for Accreditation of Healthcare Organizations (JACHO), and all mental retardation training centers are certified by the U.S. Centers for Medicare and Medicaid (CMS), formerly known as the Health Care Financing Administration (HCFA), as meeting Medicaid standards of quality. Child and adolescent services at the Southwestern Virginia Mental Health Institute and the Commonwealth Center for Children and Adolescents (CCCA), formerly the DeJarnette Center, are licensed by the Commonwealth under the CORE regulations for residential children's services.

Current operating (staffed) bed capacities for each state mental health and mental retardation facility follow.

Mental Health Facility Operating Capacities – September 2001

MH Facility	# Beds	MH Facility	# Beds	MH Facility	# Beds
Catawba Hospital	110	Hiram Davis Medical Ctr.	74	Southwestern VA MHI	195
Central State Hospital	320	Northern VA	127	Western State Hospital	287
CCCA	48	Piedmont	135	TOTAL MH Beds	1,883
Eastern State Hospital	515	Southern VA MHI	72		

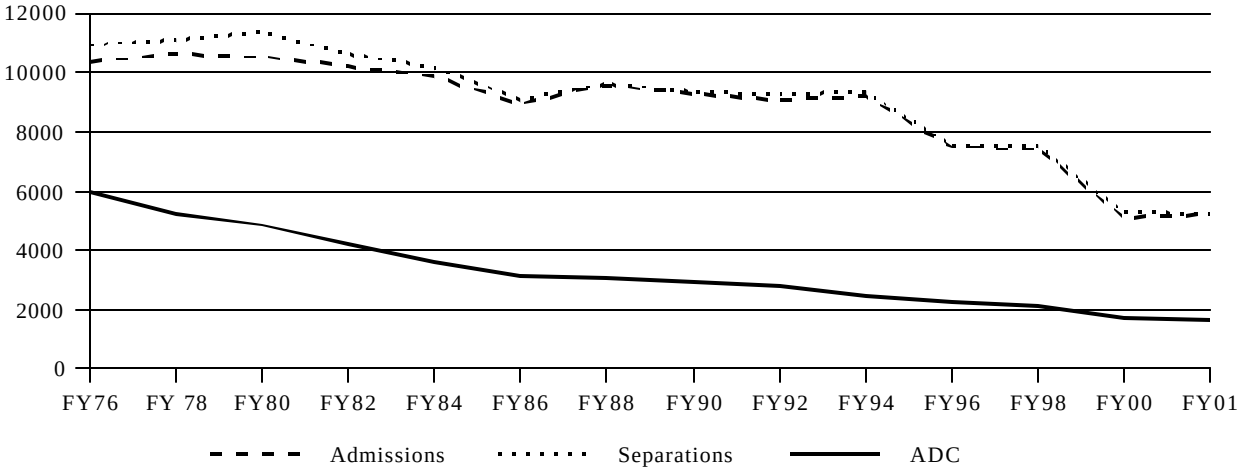
Mental Retardation Training Center Operating Capacities – September 2001

MR Training Center	# Beds	MR Training Center	# Beds
Central Virginia Training Center	664	Southside Virginia Training Center	419
Northern Virginia Training Center	200	Southwestern Virginia Training Center	223
Southeastern Virginia Training Center	200	TOTAL MR Beds	1,706

Admission, separation, and average daily census trends (FY 1976 - FY 2001) for state facilities, excluding the Hiram Davis Medical Center, follow.

MH Facility Admissions, Separations, & Average Daily Census (ADC) Trends

FY 1976 - FY 2001

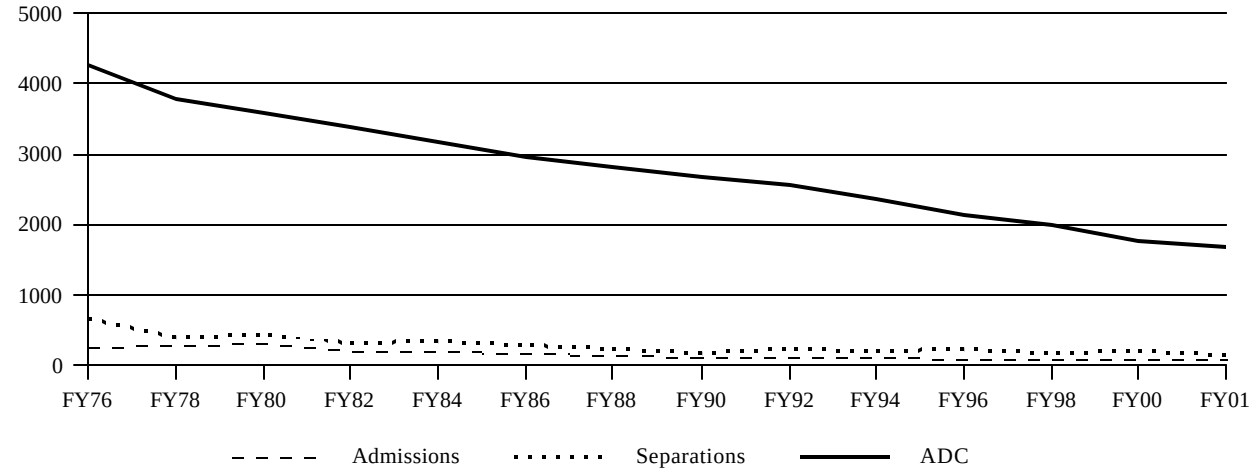


Note: The average daily census and numbers of admissions and separations includes the Virginia Treatment Center for Children through FY 91 when it was transferred to MCV.

Between FY 1976 and FY 1996, the average daily census at state mental health facilities declined by 3,745 or 63 percent (from 5,967 to 2,222). Since FY1996, the average daily census declined by 581 or 26 percent (from 2,222 to 1,641), the number of admissions declined by 2,245 or 30 percent (from 7,468 to 5,223) and the number of separations declined by 2,353 or 31 percent (from 7,529 to 5,176). Various state facility discharge and diversion projects, PACT teams, and the increased use of atypical antipsychotic medications have contributed to this decline.

MR Training Center Admissions, Separations, & Average Daily Census (ADC) Trends

FY 1976 - FY 2001



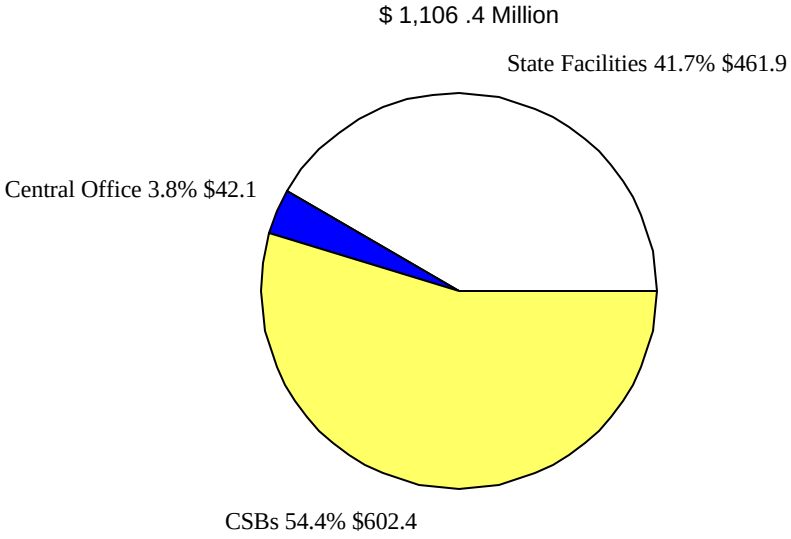
The average daily census has been declining steadily at state mental retardation training centers. Between FY 1976 and FY 1996, average daily census at mental retardation training centers declined by 2,161 or 50 percent (from 4,293 to 2,132). Since FY 1996, the average daily census declined by 451 or 21 percent (from 2,131 to 1,680).

Appendix C provides detailed state facility utilization information, including the numbers served, average daily census, admissions, separations, and utilization by CSB.

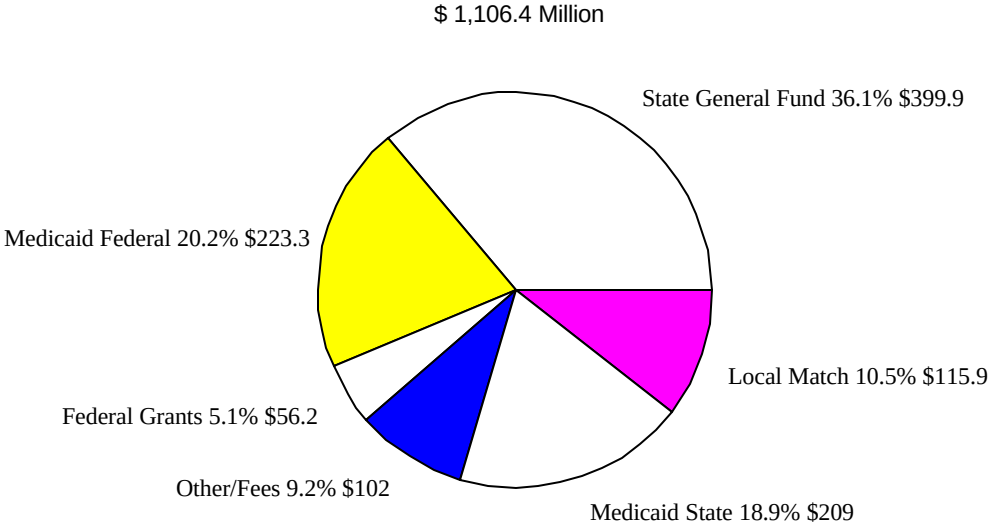
SUMMARY OF SERVICE SYSTEM FUNDING

Charts depicting the services system's total resources for **FY 2000** from **all sources** (rounded and in millions), including the Department's final adjusted appropriation, local matching funds, all fees, and Medicaid Mental Retardation Home and Community-Based Waiver (MR Waiver) payments to private vendors follow.

FY 2000 Total Services System Funding in Millions



FY 2000 Total Services System Funding in Millions by Source



SERVICES SYSTEM ACCOMPLISHMENTS

Over the past four years, Virginia's public mental health, mental retardation, and substance abuse services system has made significant progress in developing and expanding a community-based system of care and in improving the quality of care provided in state mental health and mental retardation facilities. These accomplishments include, but are not limited to:

- Virginia's 15 Programs of Assertive Community Treatment (PACT) teams (with mental health clinicians who can respond quickly to consumers around the clock) in 12 CSBs have been fully funded to serve communities having the highest historic utilization of state mental health facilities.
- Admissions to state mental health facilities between FY 1998 and FY 2001 declined by 30 percent, or from 7,431admissions to 5,223 admissions.
- State facilities and CSBs significantly expanded their use of second generation anti-psychotic medications such as Clozril, Risperidone, and Olanzapine for individuals with the most serious mental illnesses. In the 2000-2002 biennium, funding for these new medications totaled $19.95 million ($5.28 million to state facilities and $14.67 million to CSBs), making Virginia a leader among the states in expanding access to these newer medications.
- In Central Virginia, a regional Acute Care Project was established in 1999 to provide community-based acute inpatient psychiatric care for individuals who would otherwise have been sent to Central State Hospital, allowing the hospital to close its 30 bed acute admissions unit for civil patients. This project uses a regional utilization management structure. Since its inception, it has increased the number of annual admissions to acute inpatient services provided by local hospitals in the region.
- The Department's Discharge Assistance Project (DAP) has received targeted funds each year since 1998 to implement individualized services plans for state mental health facility long-term patients who been identified as clinically ready for discharge but who have significant barriers to discharge. Each discharge is monitored by the Department to ensure successful community integration. Since 1998, $12.7 million has been allocated to serve over 320 persons in community settings.
- Virginia's Medicaid Mental Retardation Home and Community-Based Waiver (MR waiver) program has been significantly expanded to provide community-based services to individuals who meet Intermediate Care Facilities/Mental Retardation (ICF/MR) eligibility criteria and who have chosen community services. In the 2000-2002 biennium, an additional $20 million was appropriated each year to expand access to this waiver. These funds supported MR waiver slots for an additional 1,448 individuals, including persons in the community and training center residents who chose to be discharged to community MR waiver services. A new MR Waiver has been submitted for federal approval. Through the work of the Department, the Department of Medical Assistance Services, and a task force comprised of consumer and family representatives and public and private providers, this waiver includes new provisions to increase opportunities for personal determination and choice.
- The five state facilities (Northern Virginia Training Center, Eastern State Hospital, Northern Virginia Mental Health Institute, Central State Hospital, and Western State Hospital) that were investigated by the Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA) have significantly improved the quality of their active treatment and

habilitation services. Through the establishment of uniform clinical and operating procedures, staffing enhancements, and targeted discharge and diversion projects, these facilities have either fully implemented or have made substantial progress in meeting the improvements outlined in the settlement agreements with the U.S. Department of Justice (DOJ). By the fall of 2001, Northern Virginia Training Center, Eastern State Hospital, Northern Virginia Mental Health Institute, and Central State Hospital had successfully implemented their plans of continuous improvement and their lawsuits were dismissed with prejudice. The remaining state mental health and mental retardation facilities are also taking positive actions to avoid similar investigations.

- The Department has implemented the first phase of its Performance and Outcomes Measurement System (POMS) measures for child and adult mental health services and substance abuse services. POMS standards for mental retardation services will be implemented in FY 2002 and standards for prevention services will be implemented in FY 2004. Full implementation of POMS will enable the Department and CSBs to uniformly assess individual outcomes, provider performance, and consumer satisfaction.
- The Department has implemented several community service initiatives that support the purchase of individualized services for individuals with more severe disabilities. These include the Discharge Assistance Project, mental health services for children who have been determined to be not mandated for services under the Comprehensive Services Act, and mental retardation services for individuals who are not eligible for Medicaid MR waiver services. For each of these programs, Department staff conduct either a prior or a concurrent services authorization of each individual's proposed services plan and monitor the provision of those services.
- Virginia has established a Mental Health Trust Fund to enable the proceeds from any future sale of vacant or surplus state facility capital resources to be used for the development of community services and to implement the restructuring of services provided by state facilities. This Trust Fund will allow for the reinvestment of resources within the services system.
- The Department has promulgated the comprehensive human rights regulations and is revising existing licensing regulations. The new human rights regulations enhance consumer protections and incorporate new statutory requirements. The revised licensing regulations, now under development, reflect new statutory requirements for increased collaboration with the Department's human rights program and add new services to be licensed, including case management, PACT teams, and new gero-psychiatric residential services.
- The Department established a new Office of Consumer Affairs.
- The Department established a Quality Council with broad representation to assist in addressing quality of care issues and expanding opportunities for improvement state facilities and CSBs. The Department also established a central medical peer review function to review professional performance of practitioners in state facilities when significant quality of care issues are identified.
- The Department instituted a number of CSB accountability enhancements, including separate reporting requirements for special projects and purchases of individualized services.
- The Department and state facilities have taken positive actions to respond to the various recommendations of the Office of the Inspector General.

III. Estimated Prevalence of Mental Illnesses, Mental Retardation, and Substance Abuse in Virginia and Current Service Demand

PREVALENCE ESTIMATES

When planning for Virginia's future public mental health, mental retardation, and substance abuse services system, it is important to have a sense of how many people might seek care from the services system. This chapter uses national epidemiological studies as the basis for extrapolating Virginia prevalence rates for adults with serious mental illnesses, children and adolescents with serious emotional disturbances, individuals with mental retardation, and individuals with substance dependence (addiction) or abuse. Prevalence is the total number of cases within a year. This differs from incidence, which is the number of new cases within a year. Total population prevalence estimates are based on the 2000 Census for Virginia.

In reviewing estimated prevalence rates, it is important to recognize that only a portion of individuals with diagnosable disorders will need to receive services at any given time and an even smaller portion will require or seek services from the public sector. For example, of the approximately 28.1 percent of the adult population with some mental or addictive disorder, the Epidemiologic Catchment Area (ECA) study found that only 8.1 percent reported that they received services in one year, or

- 3.6 percent from the mental health specialty sector,
- 2.6 percent from the general medical sector, and
- 1.9 percent from other sources (e.g., support groups and clergy).

The ECA study reported that an additional 6.6 percent of the adult population without a diagnosable mental health disorder reported use of mental health services during the year, or 2.3 percent from the mental health specialty sector, 2.4 percent from the general medical sector, and 1.9 percent from other sources. (Bourdon, Karen, et. al. *National Prevalence and Treatment of Mental and Addictive Disorders, Mental Health, United States, 1994*, Center for Mental Health Services, pp. 26-27).

Bourdon reported the following proportions of people with the following specific mental or addictive disorders received mental health or addictions treatment in either the inpatient or ambulatory service sectors during a one year period:

- Substance abuse -- 23.6 percent (co-morbid mental or addictive disorders -- 37.4%)
- Schizophrenia -- 64.3 percent
- Affective disorders -- 45.7 percent (bi-polar -- 60.9 percent, unipolar major depression -- 53.9 percent)
- Anxiety disorders -- 32.7 percent (phobia -- 31.7 percent, panic disorder -- 58.8 percent, obsessive-compulsive disorder -- 45.1 percent)
- Somatization -- 69.7 percent
- Antisocial personality -- 31.1 percent
- Severe cognitive impairment -- 17 percent
- No disorder -- 9.3 percent.

Estimated Prevalence for Adults with Serious Mental Illnesses

An estimate of the number of adults between the ages of 18 and 69 years of age with serious mental illnesses was developed using the 2000 Census and the rate (4.9) discussed in Chapter 11 - Mental Illness and Disability in the U.S. Adult Household Population of *Mental Health 2000*, published by the U.S. Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA). Public Law 102-321 requires CMHS to define adults with serious mental illness (SMI). CMHS has defined adults with serious mental illness as persons ages 18 and over who, at any time during an index year, had a diagnosable mental, behavioral, or emotional disorder than met DSM III-R criteria and "that has resulted in functional impairment which substantially interferes with or limits one or more major life activities." (SAMHSA, 1993)

The study referenced in *Mental Health 2000* used information from the 1994 Phase I National Health Interview Survey Disability Supplement (NHIS-D). The results of this survey suggest that approximately 10 percent of the civilian noninstitutionalized population between 18 and 69 have a mental or emotional problem based on the most liberal method of classification. A more restrictive classification, which requires that symptoms seriously interfere with the respondents' ability to work, attend school, or manage day-to-day activities, results in a prevalence rate of 4.9 percent. It should be noted, however, that these findings likely underestimate the true prevalence rates for mental or emotional problems among adults. Using 2000 Census data, this prevalence rate was applied to Virginia population data to extrapolate the estimated prevalence in Virginia.

Estimated Prevalence: Serious Mental Illness Among Virginia Adults

	2000 Census Virginia Adult Population (18-69)	**Estimated Prevalence (4.9%)**
Statewide	4,758,950	233,189

Estimated Prevalence for Children and Adolescents With Serious Emotional Disturbance

Public Law 102-321 also requires CMHS to define and estimate the prevalence of children with serious emotional disturbance (SED). The CMHS defines children with SED as persons from birth to age 18:

- -- who currently, or at any time during the past year,
- -- have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in DSM-IV-R; and
- -- that has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities (Friedman et. al., *Mental Health, United States, 1996*, page 72).

The CMHS established a work group of technical experts to develop the method for estimating incidence and prevalence of children and adolescents with serious emotional disturbances. A draft methodology, which adjusted for differential poverty rates, was distributed for public comment in 1996. This methodology was modified based on feedback received and published in the Federal Register on July 17, 1998.

In "*Prevalence of Serious Emotional Disturbance: An Update*" (Friedman et. al., *Mental Health, United States 1998*), two levels of serious emotional disturbance for children from age 9 to 17 were identified by the work group in 1996. The first level, which meets the requirements of the Federal definition, projects a prevalence rate of serious emotional disturbance and substantial functional impairment in the range of 9 to 13 percent. The second level, which is characterized as serious emotional disturbance and "extreme functional impairment," projects a prevalence rate in the range of 5 to 9 percent.

The work group concluded data were insufficient to make prevalence estimates for children younger than nine. It also determined that prevalence of serious emotional disturbance was higher for children living in low socioeconomic circumstances and adjusted state prevalence estimates for this difference.

In the work group's new methodology, the states are rank-ordered by the percentage of children in poverty. The estimated prevalence for the third of the states with the smallest number of children in poverty is from 9 to 11 percent (and 5 to 7 percent for extreme impairment). The estimated prevalence for the middle third of the states is from 10 to 12 percent (and 6 to 8 percent for extreme impairment). The estimated prevalence for the third of states with the highest level of poverty is from 11 to 13 percent (and 7 to 9 percent for extreme impairment). Virginia's percent of children and adolescents living in poverty in 1995 was 14.38 percent, which is in the cohort of states with the smallest number of children in poverty. Using 2000 Census data, these prevalence rates were applied to Virginia population data to extrapolate the estimated prevalence in Virginia.

Estimated Prevalence: Serious Emotional Disturbance Among Virginia Children and Adolescents

	2000 Census Child & Adolescent Population (9-17)	**Estimated Prevalence Serious Emotional Disturbance (9-11%)**	**Estimated Prevalence Serious Emotional Disturbance With Extreme Impairment (5-7%)**
Statewide	885,411	79,687 - 97,395	44,271 - 61,979

Estimated Prevalence for Individuals With Mental Retardation

The incidence of mental retardation in the United States is generally estimated at about 125,000 births per year. There is less consensus about prevalence data, however. Prevalence data is generally reported by the degree of intellectual impairment. One difficulty in obtaining consensus is due to recent changes in the definition of mental retardation that increase emphasis on a functional approach to diagnosis. This emphasis is reflected in the 1992 American Association on Mental Retardation (AAMR, formerly AAMD) definition of mental retardation. In a 1994 article on the changing concept of mental retardation, Scharlock et. al. suggested that the movement towards a functional approach to diagnosis could potentially affect prevalence rates, but not necessarily upward. This article suggested that across a number of studies conducted during the 1980s, estimated prevalence rates averaged 1.26 percent.

The *Developmental Disabilities Assistance and Bill of Rights Act Amendments of 1994*, in P.L. 103-230, Section 101 (a) (1), used a prevalence rate estimate of 1.176 percent. Prevalence estimates for mental retardation generally range between 0.7 percent and 1.2 percent of the general population. This means that in 2000, there were between 49,550 and 84,942 Virginians with a diagnosis of mental retardation.

In a 1987 review of epidemiological studies of mental retardation, McLaren and Bryson found the prevalence of both severe and mild retardation is generally 3 to 4 per 1,000, although estimates varied with gender, age, and method of ascertainment. The following table provides estimated prevalence rates by these categories as well as the estimated prevalence range for mild mental retardation (I.Q. from 50-70).

It should be noted that determination of the prevalence of mild retardation is extremely problematic, particularly because most researchers rely solely on case registration data and because diagnostic practices differ across regions and over time. These factors bring into question currently available prevalence rates of mild retardation. Using 2000 Census data, these prevalence rates were applied to Virginia population data to extrapolate the estimated prevalence in Virginia.

Estimated Prevalence of Mental Retardation

	2000 Census Virginia Population	Estimated Mild MR (0.37 to 0.59%)	Estimated Moderate MR (0.2%)	Estimated Severe MR (0.13%)	Estimated Profound MR (0.04%)
Statewide	7,078,515	26,191 - 41,763	14,157	9,202	2,831

Estimated Prevalence for Individuals With Substance Dependence

Prevalence estimates of substance dependence (addiction) in Virginia were obtained from the 1999 National Household Survey on Drug Abuse (NHSDA). The prevalence estimate of adults and adolescents reporting use of any illicit drug nationwide was 1.6 percent. The rate for alcohol dependence was 3.7 percent. Using 2000 Census data, these prevalence rates were applied to Virginia population data to extrapolate the estimated prevalence in Virginia.

Estimated Prevalence of Adolescents and Adults With Substance Dependence

	2000 Census Virginia Population Age (10+)	Estimated Number with Drug Dependence	Estimated Number with Alcohol Dependence	Total Estimate Drug and Alcohol Dependence
Statewide	6,121,449	97,943	226,494	324,437

Appendix D provides estimated prevalence numbers by CSB for each of these population groups.

SUMMARY OF CSB WAITING LIST DEMAND FOR COMMUNITY MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVICES

To document current unmet demand for community mental health, mental retardation, and substance abuse services, CSBs populated a waiting list data base developed by the Department. This waiting list data base includes specific demographic and service information about each individual identified by the CSBs as needing a specific community services or services. The CSB waiting list data base documents unmet service demand for the following populations:

- Adults with serious mental illnesses;
- Children and adolescents through age 17 with a serious emotional disturbance and young children through age seven at risk of developing serious emotional disturbance;
- Individuals with mental retardation, as defined by the American Association on Mental

Retardation (AAMR), and children under the age of ten who are determined to be at risk of developmental delay;

- Adults with substance addiction (dependence) disorders, substance abuse disorders, and co-occurring chemical addiction and mental illness; and
- Adolescents with substance addiction (dependence) disorders, substance abuse disorders, and co-occurring chemical addiction and mental illness.

Included on CSB waiting lists are individuals who were receiving no CSB services and current CSB consumers who were not receiving the types or amounts of services they needed. The CSB waiting list data base was modified this year to allow CSBs to identify more than one needed service. Each identified service had to have been clinically determined by the CSB to be needed. The service had to have been sought or requested by the individual or his family member or legally authorized representative. Unmet service needs of individuals currently receiving CSB services had to be appropriately documented in their individualized services plans (ISPs) or in an assessment for services that had been approved by the individual or his or her family member or legally authorized representative. CSBs were instructed to include needed services even if they were not currently provided by or through the CSB.

Individuals identified through CSB outreach efforts and referrals from other agencies (e.g., schools, jails) and community organizations were not to be entered in the CSB waiting list data base unless:

- the person or his legally authorized representative had either sought services from the CSB directly or was aware of his referral to the CSB by a third party and had agreed to be placed on a CSB waiting list, and
- the CSB had conducted an initial assessment to determine the individual's service needs and his membership in a priority population.

The following table displays the number of Virginians who were on CSB waiting lists for either a full range of community services or for specific residential, outpatient/case management, day support, or episodic respite or family support services on April 2, 2001. This point-in-time methodology for documenting unmet service demand is conservative because it does not identify the number of persons in need of services over the course of a year.

Numbers of Individuals on CSB Waiting Lists for Services by Population

April 2, 2001

Population	Numbers on CSB Waiting Lists Who Are NOT Receiving CSB Services	Numbers on CSB Waiting Lists Who ARE Receiving Some CSB Services	Total Numbers on CSB Waiting Lists
Adults with Serious Mental Illnesses	593	3,865	4,458
Children & Adolescents with or At Risk of Serious Emotional Disturbance	312	1,037	1,349
Individuals with Mental Retardation	892	3,324	4,216
Adults with Substance Dependence or Abuse	585	1,601	2,186

Population	Numbers on CSB Waiting Lists Who Are NOT Receiving CSB Services	Numbers on CSB Waiting Lists Who ARE Receiving Some CSB Services	Total Numbers on CSB Waiting Lists
Adolescents with Substance Dependence or Abuse	65	280	345
Total	2,447	10,107	12,554

The waiting list data base includes specific information about each individual who had been determined by a CSB to need services that are not currently being provided, including the individual's:

- Waiting list unique identifier number;
- Date of birth;
- Priority population status;
- CSB service status;
- Specialized services requirements;
- Projected service and support needs;
- Current type of residence;
- Age of primary care giver (MR);
- Risk factor;
- Date placed on waiting list and most recent service assessment; and
- Likely Medicaid MR Waiver eligibility.

Appendix E provides numbers of individuals on CSB waiting lists for mental health, mental retardation, and substance abuse services for each CSB.

SUMMARY OF STATE FACILITY READY FOR DISCHARGE DATA

The Department developed a state facility discharge data base that provides specific demographic and service information about each patient in a state mental health facility identified as ready for discharge if community services were available and each resident of a training center for whom there is agreement by the resident or his legally authorized representative for discharge to community services and supports. On a monthly basis, each state facility sends the Patient-Resident Automated Information System (PRAIS) number and other available information for each patient on its "discharge-ready" and for each resident on its "chooses discharge" list to the appropriate case management CSB. The CSB then reviews each individual's discharge plan, determines the availability of needed community services and supports, and assesses any other barriers to the individual's discharge that may exist. This information is then reported to the Department's Office of Planning and Development. This information is updated quarterly by the CSBs with new information received from each state facility.

The state facility discharge waiting list data base includes specific information about each individual who has been determined by a CSB to be ready for discharge (MH) or who has chosen to be discharged (MR), including the individual's:

- State facility PRAIS unique identifier number;
- Individual's date of birth;

- State facility
- Priority population status;
- State facility admission date;
- Date the individual was determined to be ready for discharge (MH) or date the individual or his legally authorized representative chose discharge (MR);
- Specialized services requirements;
- Projected service and support requirements in the individual's discharge plan and the current availability of each service;
- Agreement by the individual or his legal authorized representative with discharge and proposed community placement;
- Other barriers to discharge identified in the discharge plan;
- Anticipated discharge date;
- Whether the discharge dispute resolution process had been initiated; and
- Likely Medicaid MR Waiver eligibility.

The following tables display the number of individuals identified as being ready for discharge from state mental health facilities and the number of individuals identified as choosing to be discharged from training centers.

Number of Patients in Mental Health Facilities Identified as Ready for Discharge by Facility

June 30, 2001

State Mental Health Facility	Patients	State Mental Health Facility	Patients
Catawba Hospital	29	Piedmont Geriatric Hospital	17
Central State Hospital	24	Southern Virginia MH Institute	10
Commonwealth Center for Child. & Ad.	0	Southwestern Virginia MH Institute	4
Eastern State Hospital	30	Western State Hospital	5
Northern Virginia MH Institute	18	Total	137

Number of Residents in Mental Retardation Training Centers Identified as Choosing Discharge for Community Services and Support

June 30, 2001

Training Center	Residents	Training Center	Residents
Central Virginia Training Center	130	Southside Virginia Training Center	25
Northern Virginia Training Center	15	Southwestern Virginia Training Center	5
Southeastern Virginia Training Center	81	Total	256

Appendix F provides each CSB's projected numbers of state facility patients identified as clinically ready for discharge and residents who could be discharged from state facilities if they chose to be and if appropriate community services were available.

IV. Future Directions, Critical Issues, and Strategic Responses for Virginia's Publicly-Funded Services System

ACCESS TO CARE

Priority Populations

A general consensus has emerged over the past several years among consumers, family members, advocates, the Department, CSBs, and other service providers that the services system should focus its use of limited state-controlled funds on serving individuals with the greatest needs for public services. State-controlled funds are state general funds and federal funds appropriated to the Department by the General Assembly for community mental health, mental retardation, and substance abuse services. The Joint Subcommittee Studying the Future Delivery of Publicly Funded Mental Health, Mental Retardation, and Substance Abuse Services (HJR 240/225) urged the State Mental Health, Mental Retardation and Substance Abuse Services Board, in its 1998 Report (House Document No. 77), to develop policies defining priority populations. House Bill 428, proposed by the Joint Subcommittee and enacted by the 1998 General Assembly, amended §37.1-198 of the *Code of Virginia* to require that the community services performance contract, which provides state and federal funds to CSBs for mental health, mental retardation, and substance abuse services, identify groups of consumers to be served with state-controlled funds.

Priority populations are those groups of individuals, identified through uniform and consistently applied classification instruments, who have the most serious or severe disabilities, measured in terms of diagnosis and level of functioning. The *Code of Virginia* does not identify any particular group of people as having a right to services. The identification of priority populations does not create any legal entitlement to services; rather, it provides a framework for identifying who should have priority for receiving long-term services paid for with state-controlled funds. Similarly, priority populations are not intended to determine, *a priori*, how CSBs should spend their state-controlled funds or to dictate who will be served locally. Rather, priority populations track, monitor, and describe how and for whom state-controlled funds are used. CSBs identify in their fourth quarter reports the numbers of individuals in priority populations who received services.

Allocation of state-controlled funds has not changed with the implementation of priority populations. Funds continue to be allocated to CSBs based on historical funding patterns and for special projects and purchase of individualized services. State-controlled funds have not been reallocated among CSBs or restricted to services for specified priority populations.

Mental Health Priority Populations are:

- adults with serious mental illnesses, assessed along three dimensions: diagnosis, functional impairment, and duration;
- children and adolescents, birth through age 17, with a serious emotional disturbance; and
- children, birth through age17, who are at risk of developing a serious emotional disturbance.

Mental Retardation Priority Populations are:

- adults or children 6 years of age or older who have a confirmed diagnosis of mental

retardation;

- children ages 3 to 6 years of age who have a confirmed diagnosis of mental retardation or a confirmation of cognitive developmental delay; and
- children under 3 years of age with confirmed eligibility for Part C of IDEA.

Substance Abuse Priority Populations are:

- individuals with a diagnosis of substance dependence (addiction), as defined by the Diagnostic and Statistical Manual IV (DSM IV) who have used substances in the prior 12 months;
- a woman who is pregnant, a woman with dependent children, or an adult member of the mental health priority population with a diagnosis of substance abuse, as defined by the DSM IV, who has used substances in the prior 12 months;
- children and adolescents (less than 18 years old) with a diagnosis of substance abuse, as defined by the DSM IV, who have used substances in the prior 12 months; and
- adults and adolescents (less than 18 years old) who have exhibited inappropriate or dangerous behavior (e.g., damaging or destroying property, physical assault, threats of physical violence, self-injury, creating public disturbances that resulted in arrest or involuntary commitment) related to substance use within the past 12 months that resulted in intervention by the mental health and judicial systems.

The Department established a stakeholder work group comprised of CSB and advocacy organizations to assist in the development of definitions and brief, simple classification instruments for each priority population. The definitions and classification instruments for each priority population were field tested and field test results were brought back to the work group for its review and final recommendations.

The priority population definitions and classification instruments were implemented by CSBs on July 1, 2000. In March and April 2001, following the initial months of implementation, the definitions, classification instruments, and data collection protocols were reviewed for statewide reliability and validity. As a result of this review, classification instruments and protocols were streamlined to ensure a more reliable and efficient process of collecting these data. The revised instruments and protocols became effective July 1, 2001.

These definitions and classification instruments enable CSBs and state facilities to identify, monitor, track, and report on people in these populations in a consistent, verifiable manner across the state. These definitions also identify individuals to be included in the Performance and Outcomes Measurement System (POMS).

Over a period of years, the Department will compare the amounts and proportions of state-controlled funds spent by each CSB on priority and non-priority populations with the relative numbers of individuals in priority and non-priority populations. These amounts and proportions will also be compared with those of similar CSBs. Over time, performance measures will be negotiated with individual CSBs as necessary to increase the proportions of state-controlled funds that they expend on longer-term services for priority populations. The Department will not reallocate existing state-controlled funs among CSBs based on these comparisons and will not restrict the use of state-controlled funds to serving only priority populations.

Priorities for Targeted Service Development

Virginians with serious mental illnesses, mental retardation, or substance dependence (addiction) or abuse problems should receive high-quality treatment and services that are cost effective and appropriate to their service and support needs. Anyone in crisis due to a mental disability or addiction to or abuse of alcohol or other drugs should have access to an array of intensive intervention services in the community. Individuals with the most serious or severe disabilities should have access to individualized longer-term services. Virginia's future system of publicly-funded mental health, mental retardation, and substance abuse services should include two major service components:

- An expanded array of community-based, short-term intensive intervention services that provide emergency, short-term local hospitalization, detoxification, and crisis stabilization services, in essence, a services safety net; and
- A comprehensive array of longer-term services and supports that are available to adults with serious mental illnesses, children and adolescents with or at risk of serious emotional disturbance, individuals with mental retardation, young children with confirmed cognitive developmental delay or eligibility under Part C of IDEA, and persons with addictions to or, in certain circumstances, abuse of alcohol or other drugs.

Individuals receiving services should have the ability to manage their own care to the greatest extent possible. This includes participating in their services planning and choosing their care givers from among qualified public and private providers. A wide variety of home and community-centered services should be available, including an array of short-term intensive intervention and longer-term treatment, habilitation, and support services. Non-traditional services and supports such as consumer-operated peer-support programs and services provided in partnership with neighborhood and community organizations also should be available.

Expanded Array of Community-Based Short-Term Intensive Intervention or Safety Net Services

Short-term intensive intervention services would be available, within the constraints of available funds, to anyone, whether or not he or she is a member of a priority population, who needs the services to:

- address an immediate crisis that could escalate to a point where the person becomes a danger to himself or others,
- prevent a further deterioration in functioning level or life circumstances that could cause the person to need longer-term services,
- improve his ability to function effectively in personal, work, or school environments, or
- prevent the onset of a mental disability.

The Department proposes to establish a full array of community-based short-term intensive intervention services. These short-term services usually would be provided for no more than 30 days during an episode of care, unless otherwise noted below. There would be no limit on the number of clinically appropriate episodes of care provided to an individual during the course of a year. Examples of these services include, but are not limited to:

- access to a psychiatrist or other medical professional trained to perform a comprehensive assessment of psychiatric emergencies,

- short-term inpatient psychiatric care provided in community hospitals rather than in state facilities,
- emergency services (now required by law to be provided by every CSB),
- medical and social detoxification for persons experiencing acute alcohol or drug intoxication,
- short-term substance addiction residential treatment,
- mobile community crisis teams to provide outreach and short-term intervention,
- short-term respite to remove an individual from a dysfunctional environment,
- short-term crisis stabilization in residential settings to avoid hospitalization,
- intensive outpatient services for a brief period (e.g., eight visits),
- medications provided in combination with other crisis stabilization services, and
- acute partial or day hospitalization.

Short-term services also include general access services such as prevention and information and referral services.

Those individuals receiving short-term intensive intervention services who do not need services after their situation has stabilized would be able to return to their daily activities. For many individuals, quick access to local hospitalization and other crisis stabilization services, including mobile community crisis stabilization teams, would help prevent social deterioration that often occurs after an initial episode of mental illness. Community-based detoxification services would divert individuals with substance addiction (dependence) or abuse disorders from admission to state mental health facilities.

The Department continues to emphasize the transition of acute psychiatric inpatient services from state mental health facilities to community hospitals to the extent that this is possible. This transition would respond to consumer and family desires to receive services closer to home. However, the Department recognizes that in certain area of Virginia, local acute inpatient capacity may not exist. State mental health facilities would provide acute psychiatric services where such capacity is not available in local hospitals. A major challenge to the provision of acute psychiatric inpatient care in community settings is the declining availability of operating psychiatric inpatient beds in local hospitals. Additionally, over the last few years, concerns have been raised by several groups regarding problems in the delivery of emergency services and acute inpatient care in Virginia. Particular concerns follow.

- Potential conflicts between the Federal *Emergency Medical Treatment and Active Labor Act* (EMTLA) and Virginia's involuntary civil commitment law,
- Inconsistent application of Virginia's commitment laws in different communities across the Commonwealth,
- Timeliness of emergency response in some cases,
- Medical clearance for admission to state facilities,
- Responsibility for persons considered inappropriate for psychiatric hospital admission,
- Lack of ongoing communication among local participants.

To help address these issues, the Department has met periodically, since September 2000, with the Virginia Hospital and Healthcare Association (VHHA), the Virginia Association of Community Services Boards (VACSB), the Supreme Court of Virginia, the Medical Society of Virginia, the Psychiatric Society of Virginia, and the College of Emergency Physicians to identify

possible actions and solutions.

In the 2001 Session of the General Assembly, legislation proposing to set forth consistent requirements for medical evaluation and assessment prior to admission to state hospitals was introduced. Although this legislation did not pass, it generated significant dialogue on the issue of medical screening. To help address inconsistencies in the medical screening requirements of state hospitals, the Department has issued a memorandum to state hospitals clarifying medical screening and medical assessment requirements.

On June 1, 2001, the VACSB convened a task force to address the apparent shortage of acute inpatient beds, in both state and local hospitals, which has increasingly hampered the treatment efforts of local mental health providers around Virginia in recent months. The task force included individuals from CSBs, state and private hospitals, and the Department. The VACSB is considering a variety of recommendations proposed by the task force to address this issue.

Lastly, the Department is working with the CSBs to emphasize the importance of local collaboration, planning and problem solving in the delivery of local emergency services. This includes an examination of the extent to which local plans are in place to address emergency service delivery issues with the appropriate participants. The VACSB and VHHA are expected to endorse this examination and send similar messages encouraging local dialogue.

Comprehensive Array of Longer-Term Services

Some individuals receiving short-term intensive intervention services may require longer-term services and supports in addition to, or after, their short-term intensive intervention is finished. These individuals would be screened for membership in a priority population and referred to appropriate longer-term services. Longer-term services would be available, within the constraints of available funds, to anyone who is a member of a priority population and needs the services. Longer-term services would be provided, usually for period of more than 30 days during an episode of care, in accordance with the consumer's individualized services plan (ISP).

To assure that services are provided to individuals who truly need continuing care, longer-term mental health, mental retardation, and substance dependence or abuse services should be targeted to consumers in priority population categories because these individuals have the most serious illnesses or severe disabilities and present the greatest potential risk to themselves or to others (suicide, public safety, dangerousness, homelessness).

Longer-term mental health, mental retardation, and substance abuse services would include:

- clinical case management;
- extended hospitalization (longer than 30 days) provided in a state mental health facility;
- extended training and habilitation services provided in a mental retardation training center;
- Programs of Assertive Community Treatment (PACT) teams that provide intensive 24-hour psychiatric, nursing, and case management services through interdisciplinary teams;
- longer-term residential services and housing supports;
- psychosocial rehabilitation services;
- day support and employment services;
- therapeutic day treatment and intensive in-home services for children and adolescents with a serious emotional disturbance;

- medications management;
- substance abuse day treatment, intensive outpatient, and aftercare services;
- specialized psycho-geriatric services that are more intensive than nursing homes but less intensive than hospitalization;
- early intervention and Part C services;
- family support services; and
- other individualized services and supports that address the needs of consumers.

Longer-term services funded by state-controlled dollars would not include mental health individual outpatient psychotherapy, family or marital counseling, or longer-term substance abuse individual counseling. Communities that choose to provide these services could use fees paid by consumers, local public funds, third party reimbursements, or Medicaid funds for eligible individuals.

A critical element in the design and delivery of longer-term services is the expectation of recovery, rehabilitation, and self-determination, to the greatest extent possible. Service provider performance should be assessed by consumer outcomes and the extent to which the provider discourages practices and services that foster long-term dependency. Providers of longer-term services should be assessing, developing, and supporting the individual's employability and connecting individuals to job training, employment, and vocational rehabilitation services, as appropriate. Providers also should be doing everything possible to keep the individual's family structure in place for as long as this reflects his choice and that of his family. Finally, providers should be building on, rather than replacing, the individual's natural supports (family, friends, neighbors, churches, and other community organizations).

State mental health and mental retardation facilities would continue to provide extended, longer-term inpatient rehabilitation services. A full range of inpatient forensic mental health services, from acute psychiatric care to longer-term inpatient rehabilitation, would continue to be provided in a secure environment based on criminal justice system referrals. Child and adolescent acute psychiatric and longer-term inpatient rehabilitation services would continue to be provided in selected state mental health facilities.

In a point-in-time survey conducted for this Plan in April 2001, CSBs documented current demand for a range of longer-term community services and supports. This demand is described in the following section of the Plan. The Department has identified the resource required over the next two biennia to address this demand. The Department proposes to increase the number of PACT teams by two to serve an additional 160 individuals with serious mental illnesses who have histories of long or frequent inpatient stays and require continuous intensive services. The two proposed regional initiatives in Southern Virginia and Eastern Virginia also include longer-term service components. The Southern Virginia regional services plan, if funded, would establish a third new PACT team, two intensive community treatment (ICT) teams to actively monitor individuals with histories of multiple hospitalizations, two group homes, transitional living apartments, and other residential services. The Region V (Eastern Virginia) Plan for Community and Inpatient Care, if funded, would establish a variety of assertive community treatment, residential, day treatment or partial hospitalization, case management, and medical services as well as acute psychiatric services.

Documented Demand for Community Mental Health, Mental Retardation, and Substance Abuse Services

The Department asked the CSBs to complete a point-in-time automated data base to document specific service requirements of individuals on CSB waiting lists on April 2, 2001. To be included in the data base, an individual had to have sought the service and been assessed by the CSB as needing that service. A summary of this documented demand follows.

Numbers of Individuals on CSB Service Waiting Lists by Service and Population

April 2, 2001

Service	No. of Adult MH	No. of Child/ Adolescent MH	No. of MR	No. of Adult SA	No. of Adolescent SA
Outpatient Services					
Psychiatric Services	1,417	520	197	273	53
Medication Management Services	1,480	382	246	219	39
Assertive Community Treatment	263		14	29	
Counseling and Psychotherapy	1,785	791		928	171
Behavior Management			285		
Intensive SA Outpatient	309	27		788	137
Intensive In-Home		318	61		41
Methadone Detox				101	2
Opioid Replacement				80	
Case Management Services	1,405	485	1,013	628	52
Day Support Services					
Day Treatment/Partial Hospitalization	285			131	
Rehabilitation	574	16	615	36	1
Therapeutic Day Treatment		237			38
Sheltered Employment	137	9	452	11	
Supported Employment Group Model	87	10	308	33	
Transitional or Supported Employment	436	21	342	25	7
Alternative Day Support Arrangements	262	30	515	17	12
Residential Services					
Highly Intensive	239	48	462		
Highly Intensive (SA)	110	4		173	26
Intensive	168	26	1,109	453	51
Supervised	376	21	750	166	7
Supportive	700	49	993	58	4
Family Support	167	104	408	36	
Early/Infant-Toddler Intervention					
Early Intervention					6
Infant and Toddler Intervention			46		

Information about the characteristics and services needs of individuals identified by the CSBs as needing community-based mental health, mental retardation, or substance abuse services follows.

- Of the 12,554 individuals waiting for CSB services, 10,107 (81 percent) were currently receiving one or more CSB services.
  - *Adult Mental Health* - Of the 4,458 adults on waiting lists, 3,865 (87 percent) were and 593 (13 percent) were not receiving CSB services.
  - *Child/Adolescent Mental Health* - Of the 1,349 youth on waiting lists, 1,037 (77 percent) were and 312 (23 percent) were not receiving CSB services.
  - *Mental Retardation* - Of the 4,216 individuals on waiting lists, 3,324 (79 percent) were and 892 (21 percent) were not receiving CSB services.
  - *Adult Substance Abuse* - Of the 2,186 adults on waiting lists, 1,601 (73 percent) were and 585 (27 percent) were not receiving CSB services.
  - *Adolescent Substance Abuse* - Of the 345 adolescents on waiting lists, 280 (81 percent) were and 65 (19 percent) were not receiving CSB services.
- A substantial number of individuals were waiting for a single new or additional service.
  - *Adult Mental Health* - Of the 4,458 adults on waiting lists, 1,903 (43 percent) were waiting for a single service, most frequently counseling and psychotherapy (525 individuals), case management (354), supportive residential (188), psychosocial rehabilitation (162), and psychiatric services (91).
  - *Child/Adolescent Mental Health* - Of the 1,349 youth on waiting lists, 557 (41 percent) were waiting for a single service, most frequently counseling and psychotherapy (208), intensive in-home (101), case management (64), and psychiatric services (60).
  - *Mental Retardation* - Of the 4,216 persons on waiting lists, 1,955 (46 percent) were waiting for a single service, most frequently intensive residential (468), supportive residential (414), supervised residential (338), rehabilitation (154), and family support (105).
  - *Adult Substance Abuse* - Of the 2,186 adults on waiting lists, 1,195 (55 percent) were waiting for a single service, most frequently counseling and psychotherapy (294), intensive SA outpatient (287), intensive residential (250), and case management (87).
  - *Adolescent Substance Abuse* - Of the 345 adolescents on waiting lists, 180 (52 percent) were waiting for a single service, most frequently counseling and psychotherapy (71), intensive SA outpatient (48), and intensive residential (20).
- Most individuals waiting for services were identified as being in a priority population.
  - *Adult Mental Health* - 3,673 adults were assessed to be in a priority population, 345 were not in a priority population, and 398 were not assessed.
  - *Child/Adolescent Mental Health* - 935 children and adolescents were assessed to have a serious emotional disturbance, 146 were assessed to be at-risk, 77 were not in a priority population, and 172 were not assessed.
  - *Mental Retardation* - 3,828 individuals were assessed to have mental retardation and167 to have cognitive developmental delay, 17 were not in a priority population, and 186 were not assessed.
  - *Adult Substance Abuse* - 1,627 adults were assessed with substance dependence, 160 with substance abuse, and 32 with substance-related violence; 112 were not in a priority

population; and 243 were not assessed.

- *Adolescents Substance Abuse* - 153 adolescents were assessed with substance dependence and 151 with substance abuse; 17 were not in a priority population; and 23 were not assessed.

- Many individuals on CSB waiting lists had conditions or needs that could require specialized services and supports. Across all populations, the most frequently identified conditions or needs were:
  - dual diagnoses of MI/SA or MI/MR,
  - extensive behavioral needs,
  - extensive personal care needs, and
  - major medical or health conditions.

  Other major conditions or needs cited for individuals waiting for mental retardation services included verbal communication issues, developmental disability other than mental retardation, and ambulatory issues.

Numbers of Individuals on CSB Waiting Lists With Characteristics That May Require Specialized Services and Supports

April 2, 2001

Population Group or Characteristic	Mental Health		Mental Retardation	Substance Abuse	
	Adult	C/A		Adult	C/A
Forensic Status	105	9	12	93	48
Dual Diagnoses (MI/SA and SA/MI)	903	48		433	124
Dual Diagnoses (MR/MI and MI/MR)	147	30	623		
Dual Diagnoses (SA/MR and MR/SA)			9	6	3
Triple Diagnoses (MI/MR/SA)	17	0	15	5	3
Developmental Disability Other Than MR	97	61	663	14	1
Deafness or Severe Hearing Loss	47	3	152	9	0
Blindness or Severe Visual Impairment	49	3	226	11	0
Non-ambulatory or Major Difficulty in Ambulation	78	4	620	12	0
Unable to Communicate with Verbal Speech	27	5	919	2	0
Traumatic Brain Injury	72	3	61	16	1
Dementia	66		9	3	
High or Extensive Behavioral Needs	549	552	870	126	64
High or Extensive Physical or Personal Care Needs	262	34	1,062	25	1
Major Medical Condition/Chronic Health Problem	753	21	800	174	2
Limited English Proficiency (National Origin)	152	17	76	59	6
Special Education		445			

- CSBs identified specific risk factors for individuals waiting for services. Limited or lacking social supports was a major risk factor for all populations. For adults, other factors included unemployment and risk for homelessness. For youth, other factors included risk of out of home placement, lack of school attendance, and social services/criminal justice involvement.

Numbers of Individuals on CSB Waiting Lists With Identified Risk Factors by Population

April 2, 2001

Service	Mental Health		Mental Retardation	Substance Abuse	
	Adult	C/A		Adult	C/A
At Risk of Being Homeless or Out or Home Placement	1,129	169	702	570	178
Currently Unemployed or No Day Support Options	2,514	0	548	976	0
Social Supports Are Limited or Lacking	2,835	630	2,006	1,060	246
Aging Care Giver	344	67	See Note	15	10
Care Giver Illness or Disability	189	187	536	19	29
Currently Truant, Expelled, Suspended, or Dropped Out of School		192			180
Family Has Petitioned to be Relieved of Custody		18	25		5
Aging Out of CSA or Foster Care Financing for Residential Services		17	86		6
Application for Training Center Admission			15		
Social Services/Juvenile Just System Involvement		424			265
Aging Out of Special Education			541		
Currently Pregnant				18	2
Female Who Currently Resides with Dependent Children				159	
Concurrent Medical Problems (HIV/AIDs, TB, Hepatitis)				166	2
IV Drug Use				181	1

Note: For individuals with mental retardation who were waiting for services,

- 354 individuals had care givers who were over 70 years of age,
- 461 individuals had care givers who were between 61 and 70 years old,
- 970 individuals had care givers who were between 51 and 60 years old,
- 1,377 individuals had care givers who were age 50 or younger.

- Information provided by CSBs regarding MR Waiver eligibility of individuals with a diagnosis of mental retardation follows.
  - *Mental Retardation* - For the 4,216 individuals on CSB MR waiting lists, 3,180 were identified as waiver-eligible, 575 as not waiver-eligible, 326 as not assessed for waiver eligibility and 135 as not reported.
  - *Dual Diagnosis of MI/MR* - For the 147 adults with a MI/MR diagnosis, 22 were identified as waiver-eligible, 32 as not waiver-eligible, 52 as not assessed for waiver eligibility, and 41 as not reported. For the 30 children and adolescents with a dual diagnosis, four were identified as waiver-eligible, three as not waiver-eligible, 13 as not assessed for waiver eligibility, and 10 as not reported.
  - *Dual Diagnosis SA/MR* - For the six adults with a SA/MR diagnosis, two were identified as not waiver-eligible, two were not assessed for waiver eligibility, and two were not

reported. For the three adolescents with a SA/MR diagnosis, one was assessed as not waiver-eligible, one was not assessed for waiver eligibility, and one was not reported.

- CSBs identified whether children and adolescents who were waiting for mental health or mental retardation services were in a Comprehensive Services Act-mandated population.
  - *Mental Health* - Of the 1,258 child and adolescent cases cited, 221 were in a CSA-mandated population, 437 were not, and 600 were not assessed.
  - *Mental Retardation* - Of the 1,858 child and adolescent cases cited, 198 were in a CSA-mandated population, 351 were not, and 1,309 were not assessed.
- For the 1,349 children and adolescents waiting for mental health services, CSBs reported that 52 would need these services in the 2004-2006 biennium, and 66 in the 2006-2008 biennium.
- For the 4,216 individuals waiting for mental retardation services, CSBs reported that 547 would need these services in the 2004-2006 biennium and 460 in the 2006-2008 biennium.
- Most individuals waiting for services lived in a private residence or school.
  - *Adult Mental Health* - For the 4,413 cases cited, 3,431 (78 percent) lived in private residences, 309 (7 percent) lived in assisted living facilities, 207 (5 percent) were homeless or lived in a homeless shelter, and 161 (4 percent) lived in community residential programs.
  - *Child/Adolescent Mental Health* - For the 1,336 cases cited, 1,194 (89 percent) lived in private residences or schools and 94 (7 percent) had a foster home or family sponsor.
  - *Mental Retardation* - For the 4,184 cases cited, 3,511 (84 percent) lived in private residences or schools, 207 (5 percent) lives in assisted living facilities, 192 (5 percent) lived in community residential facilities, and 92 (2 percent) lived in some other institutional setting.
  - *Adult Substance Abuse* - For the 2,152 cases cited, 1,397 (65 percent) lived in private residences, 473 (22 percent) were in a local jail or correctional facility, and 100 (5 percent) were homeless or lived in a homeless shelter.
  - *Adolescents Substance Abuse* - For the 344 cases cited, 265 (77 percent) lived in private residences or schools and 49 (14 percent) were in a detention or correctional facility.

  The remaining individuals lived in a variety of types of residences.

CSBs also estimated the number of weeks individuals waited prior to their actual receipt of specific services. The longest average wait times were for residential services, especially MR child highly intensive (117 weeks), adult intensive residential (115 weeks), adult supervised residential (86 weeks), child intensive residential (85 weeks), and adult highly intensive residential (84 weeks) services. Average wait times across the CSBs for specific services follow.

Average Service Wait Times in Weeks Across CSBs by Service and Population

April 2, 2001

Service	Mental Health		Mental Retardation		Substance Abuse	
	Adult	C/A	Adult	C/A	Adult	C/A
Initial Assessment	4.7	4.6	3.4	3.1	3.4	3.4
Outpatient Services						
Psychiatric Services	5.8	5.9	18.7	4.9	5.4	6.6
Medication Management Services	5.4	5.9	14.3	3.7	5.1	6.0
Assertive Community Treatment	17.7					
Counseling and Psychotherapy	5.3	5.8			3.6	4.3
Behavior Management			21.8	5.5		
Intensive SA Outpatient					2.4	5.7
Intensive In-Home		3.9				
Methadone Detox					5.3	
Opioid Replacement					5.7	
Case Management Services	10.3	4.2	21.4	12.6	3.6	3.2
Day Support Services						
Day Treatment/Partial Hospitalization	3.5				2.7	
Rehabilitation	8.1	1.5	39.2	25.0	4.3	
Therapeutic Day Treatment		9.0				
Sheltered Employment	11.8		30.1	27.0	5.4	
Supported Employment Group Model	22.9		29.8	20.5	4.3	
Transitional or Supported Employment	8.4	8.6	19.5	4.0	4.2	
Alternative Day Support Arrangements	3.7	6.6	29.8	38.0	4.3	
Residential Services						
Highly Intensive	47.2	3	83.9	117.0	8.7	2.2
Intensive	44.0	10.0	114.8	84.9	6.6	4.0
Supervised	29.6	4.0	86.2	57.6	7.6	13.0
Supportive	31.0	4.0	61.8	28.1	2.9	2.8
Family Support	2.9	7.1	18.8	11.9	2.8	7.0
Early/Infant-Toddler Intervention						
Early Intervention						2.2
Infant and Toddler Intervention				1.6		

Prevention Services

Substance Abuse Prevention Services

The Department is the single state authority for the federal Substance Abuse Prevention and Treatment (SAPT) block grant. Federal regulations direct the use of SAPT block grant funds. The Department's Office of Substance Abuse Services oversees and manages substance abuse

prevention and treatment services delivered through the CSBs. Prevention services include activities that involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of mental illness, mental retardation and other developmental disabilities, and alcohol and other drug dependence and abuse by enhancing protective factors and reducing risk factors.

The Department adopted a community-based prevention planning process in 1995. Each CSB was asked to convene a group of service providers, representatives of schools, business, social organizations, the faith community, and law enforcement in each jurisdiction within its catchment area. The task was to conduct a needs and resource assessment; identify service gaps and unserved populations; and plan, implement, and evaluate prevention programs that address the service gaps and identified risk factors. Each jurisdiction in Virginia participates in a single- or multiple-jurisdictional prevention planning process.

The prevention planning process is consistent with that used by the Virginia Departments of Education, Criminal Justice Services, and Juvenile Justice is required for grant applications submitted to these systems and the Governor's Office on Substance Abuse Prevention. All CSB prevention services supported by SAPT block grant prevention set-aside funds must address risk factors and services priorities identified by community-based prevention planning groups. The needs assessment for high risk youth and families developed for the 2002-2008 Comprehensive State Plan was conducted by the community-based prevention planning groups.

In FY 2000, the Department funded, through a competitive grant process, nine community services boards to replicate science-based prevention programs for families. Funding for three more programs will be made available in FY 2002. These programs include services for new parents, for parents and their children who attend Head Start, and families with children and adolescents. Each program has separate activities for parents and youth as well as family activities. Program directors are working closely with program developers and university faculty to evaluate the programs. For the 2002-2004 biennium, the Department is proposing to establish 15 new science-based prevention programs. The programs, if funded, would focus on reducing risk factors and increasing skills with gains maintained over time.

Interagency Youth Suicide Prevention

The Department is working with the lead agency, the Virginia Department of Health, and the Department of Education to implement the *Virginia Youth Suicide Prevention Plan*. An external advisory group, the Virginia Youth Suicide Advisory Committee, has been formed and meets on a quarterly basis. This group is comprised of CSB representatives, various advocacy groups, and the Virginia Suicide Prevention Council. The Virginia Suicide Prevention Council, which is a citizen's group organized to formulate a suicide prevention plan for Virginia across the lifespan, has been instrumental in advocating for the *Virginia Youth Suicide Prevention Plan*.

Funding was appropriated by the 2000 General Assembly in the amount of $75,000 for each year of the biennium. With this funding, the Department has implemented a Statewide Suicide Intervention Skills Training Network. There are 46 trainers across Virginia who are conducting two-day practice-oriented workshops in the area of suicide prevention and intervention. The Department has also conducted public awareness and education activities. Additional funding will be needed to implement a comprehensive statewide youth suicide prevention plan.

Prevention of Youth Access to Tobacco Products

The Synar Amendment (Section 1926) to the Public Health Service Act requires states, as a condition of receiving the SAPT block grant, to have in its code and enforce a law that prohibits sale or distribution of tobacco products to youth under the age of 18. In the *Code of Virginia*, this prohibition is clearly stated in §18.2-371.2. States must annually negotiate a rate of allowable noncompliance and demonstrate enforcement by conducting inspections of randomly selected retail outlets to test compliance with the amendment. Failure to achieve the target can result in a penalty of up to 40 percent of a state's SAPT block grant award. Virginia's current negotiated rate is 20 percent, and the state has achieved a rate of 19 percent for this period.

In addition to the penalty, however, there are other consequences of youthful tobacco use:

- One-third of all teenagers who use tobacco will die of tobacco-related disease; and
- Tobacco use among youth is linked to behavioral health problems such as anxiety disorders, depression, and drug abuse.

Several Virginia agencies have distinct programs that focus on youth access issues. The *Code of Virginia* charges the Department of Alcoholic Beverage Control with enforcing prohibition of sales and distribution of tobacco products to youth (§18.2- 371.2). This agency conducts inspections of retailers for Synar compliance under an interagency agreement with the Department of Mental Health, Mental Retardation and Substance Abuse Services.

The Department of Health has a well-established Office of Tobacco Use Control that has developed community-based coalitions and successful public information campaigns focused on prohibiting youth access. The Department of Mental Health, Mental Retardation and Substance Abuse Services entered into an interagency agreement with the Department of Health to take advantage of its staff's expertise in this area. The resulting campaign included window posters, lapel stickers, merchant pamphlets, billboards, and bus signs. Radio public service announcements were developed to stress the importance of the role of parents in preventing tobacco use and to inform them of the risks for physical health and drug abuse linked to smoking. The Department also awarded $400,000 to CSBs ($10,000 each) for the explicit purpose of creating programs that would encourage youth not to smoke and provide assistance in stopping.

The 1999 Session of the General Assembly established the Tobacco Settlement Foundation to "assist in financing efforts to restrict the use of tobacco products by minors through such means as educational and awareness programs on the health effects of tobacco use on minors and enforcement of laws restricting the distribution of tobacco products of minors" (§32.1-355).

Access Issues for Specific Populations

Older Adults

The mission of the Department is to improve the quality of life for all citizens of the Commonwealth who are at risk of severe mental disabilities or substance dependence or abuse. One of the most rapidly growing segments of this population is elderly adults. According to *Mental Health: A Report of the Surgeon General* (1999), a substantial proportion of the population 55 and older B almost 20 percent B experience specific mental disorders that are not part of "normal" aging. This means that of the 1,423,944 Virginians who are 55 years old and older (2000 Census), an estimated 281,940 have a specific mental disorder that is not associated

with aging. Best estimate one-year prevalence rates for specific mental disorders, based upon epidemiological catchment area information described in the *Surgeon General's Report,* follow.

Estimated One Year Prevalence Rates in Virginia of Mental Disorders Not Associated with Aging Based Upon Epidemiological Catchment Area Information

	Prevalence (%)	Estimated Number of Virginians Age 55 and Older with a Mental Disorder
Any Anxiety Disorder	11.4	162,329
Any Mood Disorder	4.4	62,653
Schizophrenia	0.6	8,543
Somatization	0.3	4,271
Severe Cognitive Impairment	6.6	93,980
Any Disorder	19.8	281,940

Mental Health: A Report of the Surgeon General, Chapter 5 Older Adults and Mental Health (page 336), source of prevalence estimates: D. Regier and W. Narrow, personal communication, 1999.

The *Surgeon General's Report* further states that researchers estimate that an *unmet* need for mental health services may exist for up to 63 percent of adults aged 65 years and older with a mental disorder (p. 341). Given these figures, the development of a standardized assessment tool to screen older individuals and the use of clinical guidelines specifically designed for the elderly population are critically important.

The provision of mental health, mental retardation, and substance abuse services to older adults is made complex by the lack of providers trained to serve this population and the limited number of specialized community-based programs in Virginia that serve older adults. The growing need to better serve older adults, including those with mental disabilities, represents a shift in this culture's perspective on older persons. Where society once assumed that older adults required no more than custodial or end-of-life care, increased longevity; a renewed respect for the social, political, and economic contributions of this population; and the demand for more appropriate treatment choices by individuals who receive services have placed pressures on service delivery systems to develop new treatment models. Treatment models for elderly persons with mental disabilities must be well coordinated, respond to the unique needs of a population with growing health issues, and provide services that promote new roles for individuals who seek to continue as productive members of their communities.

In November 1999, the Department issued a *Study of the Feasibility of Providing Specialized, Non-Acute Care to Gero-psychiatric Consumers*. This study was prepared in response to Budget Bill language (Item 342, 1999). This study concluded that there is a need for community-based non-acute specialized service capacity for this population in Virginia. This study identified best practices in gero-psychiatric care to include consumer-centered, family-focused, and community-based support and treatment interventions, with the goal of diverting hospitalizations to the extent possible and minimizing disruption to the community placement when hospitalization is necessary. This requires a comprehensive continuum of community-based care. In a best practices model, state facilities would provide acute psychiatric stabilization and training and technical assistance to build community capacity. The study cited several examples of best practices in facility and community based gero-psychiatric care, including the following.

- The Mary Starke Harper Geriatric Center was established by the state of Alabama in 1996. The Center provides specialized care to consumers with dementia and serious and persistent mental illnesses such as schizophrenia and affective disorders. Its goal is to reduce lengths of stay through the implementation of age-specific assessment and treatment and enhanced use of specialized community services. The Center emphasizes and provides training and technical assistance on the development of community capacity for this population. A network of trained community care givers, including public and private providers, family members, and higher education students, has been established to divert potential admissions, where appropriate. This same network facilitates transition of Center admissions back to the community when hospitalization is no longer needed.
- Older Adult Behavioral Crisis Services, located in Oregon, provides community-based crisis care for gero-psychiatric consumers. The program's goal is to maintain older adults with mental illness and dementia in the community through expanded outreach and treatment to people in their homes. A specialized geriatric team performs on-site assessment, does treatment planning, and recommends psychotropic medications. This team may include a staff psychiatric aide who is able to stay in the consumer's home throughout a crisis. Follow-up counseling for the older adult and family members is available.

Additionally, psychosocial rehabilitation (PSR) is one treatment model that is rapidly expanding to include services to assist order adults gain new roles, new skills, and new hope for a productive life. The PSR model is based on a set of values and technologies that promotes self-determination, growth, and the achievement of rehabilitation and recovery goals. The Department retained the services of the Boston Center for Psychiatric Rehabilitation, Inc. (BCPR) to assess the preparedness of each state facility to provide PSR services and to train staff in PSR technologies.

In its *Study of the Feasibility of Providing Specialized, Non-Acute Care to Gero-psychiatric Consumers*, the Department concluded that community-centered, family-focused and community-based services constitute best practice in gero-psychiatric care. Inpatient psychiatric facilities should support community capacity through provision of short-term acute psychiatric stabilization services. With adequate financial incentives to promote provider development and interest, the report suggested that there would be a market for specialized non-acute geriatric service models. The study further recommended the promotion of regional CSB planning to develop a comprehensive continuum of care for geriatric consumers and the provision of financial resources for the development and implementation of services based on best practices.

In recognition of evolving perspectives on the nature of mental health services for older adults and the settings in which they are delivered, the Department has convened a panel of experts to discuss the development of community gero-psychiatry services and, in particular, the type of residential gero-psychiatric service that might best serve this population. The panel, which includes representatives from the University of Virginia and Medical College of Virginia Departments of Psychiatry and state facilities, is examining the types of patients that would be appropriate for such a service and how such a program might be organized and operated.

The group has begun to review a variety of treatment models, including development of a mobile consultation/treatment team, development of a specialized wing in a nursing facility with augmented staffing levels, and development of a separate residential facility to provide assessment and treatment. They also are giving consideration to the need for a review of the

entire system of publicly delivered gero-psychiatric care in order to assess the sufficiency, comprehensiveness, and coordination of services. While every community in Virginia is served by an Area Agency on Aging that assists with services to older adults, generally, there is no administrative body responsible for integrating the array of services needed specifically for elderly individuals with severe mental illnesses.

The Department also is exploring ways to improve treatment services to older adults in psychiatric hospitals and in communities. All of the Department's geriatric hospitals and centers now have active treatment malls that incorporate PSR values of person orientation, support, involvement, active participation, self-determination, and outcome orientation. A few CSBs now provide PSR services that are specifically targeted to elderly adults in community settings. Further work is needed, however, in a number of critical areas, including:

- Ongoing training regarding the clinical benefits of PSR for older adults in helping them establish new roles and maintain or regain skills that will help them to live a more independent life;
- Training on PSR program development for elderly persons and training for staff to deliver PSR services to this population;
- Dissemination of information about successful PSR programs for elderly adults to CSB programs with literature, guidance materials, and contact information to encourage and support the development of new and expanded CSB programs for this population; and
- Facilitation of meetings, conferences, and consultation visits between CSB and state facility PSR programs to expand the range of options and provide for greater continuity in services to older adults in both settings.

To address the needs of individuals with Alzheimer's Disease, Virginia has established an Alzheimer's Disease Response Task Force. Priorities of this Task Force include:

- Providing information about Alzheimer's Disease to primary care physicians, nurses, practitioners, physicians' office nurses, and other health professionals who can assist in identifying and caring for persons with the disease;
- Reviewing existing educational and continuing education programs for health care and human services professionals to make sure information about Alzheimer's Disease is included in the curriculum; and
- Identifying the weakness and gaps in the system and using this information to guide collaborative efforts, focusing first on state agencies and then on regional and local organizations and service providers.

As all people age, their daily activities change and there is a general expectation of retirement from typical sources of work activity. Many people experience increased physical, sensory or cognitive problems that limit capacity in some ways. The same facts are true for people with mental retardation, sometimes to an accelerated degree, because or other physical or cognitive complications that already exist.

Residential services providers, regulators, and funding sources should recognize the legitimacy of offering general support and supervision, as opposed to training, as people with mental retardation grow older. The greatest source of funding for community services for people

with mental retardation in Virginia is the Medicaid MR Waiver. Currently, the MR Waiver is established to provide developmental and training services for people who would otherwise require similar services in an institutional setting, most often one of Virginia's five training centers. Aging Virginians with mental retardation are increasingly unable (or unwilling) to participate in day or residential support programs that focus on acquiring new skills. The emphasis on training that is inherent in the current MR Waiver construction means that consumers who need only general support and supervision risk losing eligibility for Waiver services. Virginia can not afford to replace community-based services with institutional services, financially or morally, simply because a consumer needs to "retire" from active treatment.

Many older adults need treatment for alcohol and drug abuse disorders and do not receive it. Alcohol abuse and prescription drug misuse affect as many as 17 percent of older adults. Because of insufficient knowledge, limited research data, and hurried office visits, health care providers tend to overlook substance abuse and prescription drug misuse among older people, mistaking the symptoms for those of dementia, depression, adverse drug reactions or other problems common to older adults. Additionally, older adults are more likely to hide their substance abuse and are less likely to seek professional help (SAMHSA-CSAT Treatment Improvement Protocol #26).

Older adults who "self-medicate" with alcohol or prescription drugs are more likely to characterize themselves as lonely and to report lower life satisfaction (Hendricks et. al., 1991). Older women with alcohol problems are more likely to have had a problem-drinking spouse, to have lost their spouses to death, to have experienced depression, and to have been injured in falls (Wilsnack and Wilsnack, 1995).

Misuse and abuse of alcohol and other drugs may take a greater toll on affected older adults than on younger adults. In addition to the psychosocial issues that are unique to older adults (unresolved loss, progressive family and social isolation, sensory deterioration), age-related biomedical changes influence the effects that alcohol and drugs have on the body and may accelerate the normal decline in physiological functioning that occurs with age (Gambert and Katsyoannis, 1995). Alcohol and drug use may elevate older adults' already high risk for injury, illness, and socioeconomic decline (Tarter, 1995).

Children and Adolescents

Mental Health: A Report of the Surgeon General Surgeon cites concerns about inappropriate diagnoses of children's mental health problems. Too often, children with mental health problems do not receive services until they end up in a secure setting such as a hospital, detention center, jail, or a state juvenile correctional facility. Mental disorders with their onset in childhood and adolescence include:

Selected Mental Disorders of Children and Adolescents from the DSM IV

- Anxiety disorders
- Attention-deficit and disruptive behavior disorders
- Autism and other pervasive developmental disorders
- Eating disorders
- Elimination disorders
- Learning and communication disorders
- Mood disorders (e.g. depressive disorders)
- Schizophrenic disorders
- Tic Disorders

Source: Mental Health: A Report of the Surgeon, Chapter 3: Children and Mental Health, (page 137).

According to the *Surgeon General's Report*, both biological factors and adverse psychosocial experiences during childhood influence, but do not necessarily "cause," mental disorders in

children. Their effect depends on individual differences among children, the children's ages, and whether these factors or experiences occur alone or in combination with other risk factors. The *Report* cites the following risk factors for developing mental disorders or experiencing social-emotional problems:

- Prenatal damage from exposure to alcohol, illegal drugs, and tobacco;
- Low birth weight;
- Difficult temperament or and inherited predisposition to a mental disorder;
- External risk factors such as poverty, deprivation, abuse, and neglect;
- Unsatisfactory relationships;
- Parental mental disorders; and
- Exposure to traumatic events. (*Surgeon General's Report*, p. 129)

These risk factors are included within the Department's priority population definition of at-risk of developing a serious emotional problem.

A growing body of empirical evidence estimates a prevalence rate as high as 50 percent for the co-occurrence of alcohol and other drug use among adolescents with mental health disorders. Recent studies suggest that these adolescents have special treatment needs, including:

- attention to developmental and other characteristics of adolescents,
- a treatment focus that examines and involves the adolescent's social and familial networks,
- the adaptation of clinical interventions for adolescents with dual diagnoses, and
- the need for services to be coordinated and integrated across multiple systems and points of contact. (Petrila, Foster-Johnson and Greenbaum, 1996)

Coordinating mental health and substance abuse systems of care would address the complex needs of adolescents with both problems. Service needs for adolescents coping with co-occurring disorders include crisis intervention, inpatient programs, residential treatment programs, day treatment programs, and outpatient counseling. (Fleich, 1991)

According to the Department of Education *Report of Children and Youth with Disabilities Receiving Special Education* (2000), there are 15,947 children between the ages of 3-22 in special education with a diagnosis of mental retardation. Of these children, 10,842 are diagnosed with mild mental retardation (68 percent), 2,536 with moderate mental retardation (16 percent), 1,236 children with severe and profound mental retardation (8 percent), and 1,333 children with autism (8 percent). CSBs served 4,998 of these children in FY 2000. Currently, there are 50 children on the Medicaid MR Waiver, and services for 32 of these children are paid for with Comprehensive Services Act (CSA) funds.

The Department has typically addressed the needs of children according to the specific disability area in which the child entered services. Nationally, as well as in Virginia, increasing emphasis is being given to integrating treatment services and supports for this population. Regardless of how their needs are identified in a system of care, children and adolescents should have access to mental health and substance abuse prevention services, adequate assessments, evaluation and diagnosis, and appropriate treatment when needed.

Since the late 1980s, Virginia has focused on developing systems of care that include: a comprehensive array of services and supports, strength-based individualized services planning,

least restrictive services environments; home and community-based services, family involvement and partnerships, cross-agency coordination, cultural competence, early identification, and accountability through outcome evaluations. (Stroul and Friedman, 1986, 1994). Emphasis has been placed on building CSB foundation services. For children and adolescents with mental health needs, foundation services include emergency, specialized outpatient, intensive in-home, day treatment, individualized therapeutic home, case management, respite, and family support services. For younger children, foundation services include case consultation in an early childhood setting such as a home, center, family-based child care, or preschool program; early intervention services; case management; and family supports. All CSBs now offer:

- Emergency and case management services, outpatient counseling, and prescreenings for state psychiatric hospital admissions for children with or at risk of developing a serious emotional disturbance;
- Family support and early intervention services for children with mental retardation and developmental delays; and
- Outpatient counseling for children and adolescents with substance abuse treatment needs and substance abuse prevention services.

However, the availability of specialized services for children with mental health, mental retardation, and substance abuse needs vary across CSBs. Not all CSBs provide mental health in-home services, day treatment, respite care, and sponsored placement services. Some CSBs provide day care subsidies and MR Waiver services for children.

Additionally, the Department has piloted demonstration projects to improve access to child and adolescent mental health services, collaborated with other state agencies to design and improve the Comprehensive Services Act, and implemented individualized community services to address the mental health needs of children and adolescents whose services are not mandated under the CSA.

The number of children served by CSBs in 1998, 1999 and 2000 has continued to increase. In 2000, CSBs served 41,231 unduplicated children and adolescents age 17 and under across all three disabilities, as compared to 40,676 in 1999 and 39,095 in 1998. However, there continue to be gaps in the provision of and access to prevention and treatment services and supports needed by children and adolescents and their families.

In addition to services provided by the CSBs, the Department operates a 48-bed psychiatric hospital for children and adolescents and a 16-bed adolescent unit for adolescents, which provide a range of inpatient treatment services. In FY 1998, 1999, and 2000 the Department served 755, 700, and 615 children and adolescents, respectively, in state mental health facilities.

The *Surgeon General's Report* suggests that mental disorders in children and adolescents must be considered within the context of the family, peers, school, and community. This requires collaboration with family members and school, juvenile justice, health, social services, education, and other service providers. The CSAT Treatment Improvement Protocols (TIPS) indicate that traditional substance abuse treatment interventions may not be adequate to meet the needs of alcohol or other drug abusing adolescents. The multiple problems facing these adolescents require that a full range of comprehensive and integrated services be available so that a specific treatment approach can be tailored to the needs of each young person. In Virginia, state and local collaborative efforts have continued across agencies that traditionally serve children, including the

Departments of Medical Assistance Services, Social Services, and Criminal Justice Services, to improve the provision of services.

The Department supports serving children in their natural home or in a family-like home where the provider is trained and approved to care for children with disabilities. When this is not possible, services and supports should be provided, to the extent possible, in community-based programs in the child's home community. The VACSB Child and Family Council has proposed an array of services that includes:

- Crisis intervention with 24 hours per day/seven days per week crisis intervention and psychiatric services, inpatient hospitalization and detoxification for persons with substance abuse;
- Intensive community-based services that include in-home individual and family therapy; intensive in-home services; psychiatric services; medication management; individual, group and family therapies; therapeutic day treatment; therapeutic preschool services; and intensive substance abuse outpatient services;
- Specialized vocational training and transition services;
- Community-based residential services that include crisis stabilization units, substance abuse residential treatment, therapeutic foster care, community group homes, and programs for independent living;
- Case management that is targeted, intensive, and family-focused; and,
- Family support services that include respite, child care, specialized transportation, community-based parenting classes and support groups, and in-home parenting training.

All these services are essential in developing the components of a quality system of care for children and adolescents. With the individualized service model implemented by the Department in FY 2001 for non-CSA mandated children and adolescents, CSBs have been able to provide individualized services needed to more than 500 children in FY 2001.

The 2000-2002 Appropriation Act included language directing the Department and the Department of Medical Assistance Services, in cooperation with the Office of Comprehensive Services, CSBs, and court service units to develop an integrated policy and plan, including the necessary legislation and budget amendments, to provide and improve the access by children to mental health and mental retardation services. The plan, which is currently being developed, will identify the services needed by children, the cost and sources of funding for the services, the strengths and weaknesses of the current services delivery system and administrative structure, and recommendations for improvements. A focus on substance abuse services was added by the Department.

The goal of the *Children's Integrated Policy and Plan* is to provide improved access for children and adolescents and their families to needed mental health, mental retardation, and substance abuse services. This plan will include specific action steps to strengthen Virginia=s continuum of care for children and adolescents, address service capacity gaps, respond to geographical access issues and technical needs, and identify resource requirements. The Department is working to include all key stakeholders in the development of this plan. The preliminary plan will be developed during FY 2002.

Persons with Diagnoses of Mental Retardation and Co-occurring Mental Illness

It is estimated that 20 to 35 percent of all people with mental retardation also have a diagnosis of mental illness. (Fletcher, National Association on Dual Diagnosis). Virginia prevalence data suggests that, of the approximate 68,000 Virginians with some level of mental retardation, approximately 13,000 to 24,000 also have a psychiatric disorder. This presents Virginia's system of state facility and community-based services with the challenge of appropriately diagnosing and supporting and treating consumers with a dual diagnosis of mental retardation and mental illness. Adequately addressing the needs of these individuals is essential because they:

- May be placed in either state facility or community programs that fail to appropriately address the combination of support and treatment needs that exist;
- Frequently exhibit behaviors that place them and the public at risk of physical harm or may lead to encounters with the correctional system in lieu of clinically-based appropriate supports and treatment; and
- Require some of the most costly interventions and support initially, and often for long periods of time, due to the nature of their behaviors.

The lack of required formal training for physicians and psychiatrists in developmental disability issues compounds the difficulty in getting the correct diagnosis or treatment. This can be complicated by an incomplete medical history, difficulty in doing an assessment, and the inability of family members or other care givers to recognize and report symptoms of mental illnesses. For too many individuals, intervention with appropriate resources is generally forced through crisis situations, with most discussion focused on who is responsible for addressing the consumer's immediate problem.

Best practice in the field of mental retardation includes development of a support plan that is driven by a holistic assessment of the consumer; a thorough medical assessment; and the inclusion of consumer and family goals for achievement, community inclusion, and quality of life. Behavioral support plans typically become part of the overall service plans, developed from a functional assessment to identify problem behaviors and identification of "triggers" or environmental issues.

Through techniques of Positive Behavioral Support (PBS), many families and providers are trained in understanding how consumers communicate pain, distress or frustration with various situations in their lives. Providers and families can adjust activities to address the underlying causes of the behaviors. However, for consumers experiencing co-occurring mental illness, PBS techniques in and of themselves are not sufficient to address other psychiatric issues that may require other types of treatment or medication management regimens. The difficulty in adequately assessing a co-occurring mental illness is exacerbated by the frequent inability of the consumer to verbalize emotions or otherwise relay experiences that are critical in the diagnostic process for persons who do not have mental retardation. Adding to assessment difficulties is the potential for undiagnosed medical conditions, adverse reactions to medication, and the impact of trauma and post-traumatic stress disorders or other personal experiences that are either unreported or not considered by either area to be mental retardation or mental illness.

The Department is working to overcome the current segregation that exists between mental health and mental retardation services at both the state and local levels. While these services are

administered by a single entity at both the state and local levels, language, philosophy and expected outcomes vary widely. The development of adequate supports and treatment for a unique population requires a multi-disciplinary approach, involving state facility and community program directors, community mental retardation and mental health providers, direct care staff, and families. Demand for state facility admission, whether to a mental retardation training center or state mental health facility, is directly affected by the availability of appropriate community interventions and supports. Discharge from state facilities is complicated by the lack of willing and competent community providers to accept and support persons ready for discharge. Limited community options and the recent unwillingness of local psychiatric hospitals to accept consumers with a dual diagnosis have increased demand on state facilities to admit consumers who have no community placement options and to keep them long after their psychiatric crisis has stabilized.

The MR Waiver has been a significant source of funding for persons with mental retardation at risk of placement in an intermediate care facility (ICF/MR). As of September 1, 2001, approximately 5,400 Virginians have been identified as eligible for MR Waiver services. An undetermined number of these individuals have a co-occurring mental illness, a diagnosis that is not requested in the data collection process. Anecdotally, the Department's Office of Mental Retardation knows that a growing number have a dual diagnosis, based on state-level intervention in crisis and state facility admission or discharge events. Expansion of the Centers of Excellence models to all training centers could allow MR Waiver providers to access expert behavioral consultation, training, and other support services that will assist providers respond to the specific treatment and support needs of individuals with diagnoses of mental retardation and co-occurring mental illness.

During FY 1999-2000, 76 individuals were discharged into the MR Waiver from state hospitals through a targeted initiative for this population. Many of those individuals had experienced frequent readmissions because traditional MR Waiver programs do not have the capacity or expertise to accommodate the unique combination of treatment and support needs those consumers require.

Persons Requiring Opioid Treatment

The demand for treatment services for prescription drug abuse and heroin addiction has increased steadily in Virginia for the past two years. Programs in the Southwest region of Virginia are reporting that 40 percent to 65 percent of their current substance abuse intakes involve the abuse of the prescription drugs Oxycontin and Oxycodone, which are both opioids. Additionally, publicly-funded programs throughout Virginia are reporting an increase in consumers seeking treatment for heroin addiction. The U.S. Center for Substance Abuse Treatment attributes the increase in heroin use and consequent demand for treatment to the high purity levels of heroin in recent years, compared to the relatively low grade quality of earlier decades.

This current trend has overwhelmed the treatment capacity for other addictive drugs, such as alcohol and cocaine. Opioid drug-addicted consumers require multiple interventions, including detoxification, outpatient and intensive outpatient services, and, in most instances, pharmacological (methadone, LAAM) services to address associated severe withdrawal and detoxification symptoms. The services that this population will require may ultimately cause a reduction of services for persons addicted to alcohol and other non-opioid drugs. Opioid-addicted

individuals who lack access to treatment are at high risk of engaging in criminal activities, quitting their jobs, and engaging in behaviors that may lead to fatal medical consequences, such as overdose, the transmission of communicable diseases (Hepatitis B and C, HIV, and STDs), and even death. It is also common for their immediate family environments to become increasingly unstable.

The Department supports the development of a systemic treatment infrastructure that adequately meets the services demands of this population as part of the state=s continuum of services provided to individuals seeking services for alcohol and drug addictions. Recently, the Department's Office of Substance Abuse Services staff have been assisting CSBs and substance abuse treatment providers in the Southwest region and other areas facing community resistance to opioid treatment to increase awareness of opioid addiction and knowledge about best practice treatment interventions such as methadone maintenance. This treatment modality has been demonstrated to have the best treatment outcomes for this population. However, resistance to this treatment modality may be grounded in views that methadone is a "substitute" for opiates. In fact, this modality is a highly valuable form of "replacement" therapy much as insulin is a replacement therapy for individuals with diabetes. Additionally, the Department has sponsored, and will continue to sponsor workshops for substance abuse treatment providers that focus on scientifically-researched and evidence-based treatment models for persons addicted to opioids. These models include: medical and social long- and short-term detoxification, emergency services, residential services, intensive outpatient services, pharmacological maintenance and detoxification services, case management, and other support services.

Persons Involved with the Criminal Justice System

The Department supports a number of programs providing mental health and substance abuse services for adults in local and regional jails and children and adolescents in juvenile detention centers. The *Code of Virginia* requires that CSBs maintain written agreements with courts and local sheriffs relative to the delivery and coordination of services (Section 37.1-197). The Department's FY 2002 community services performance contract states that CSBs shall:

- Provide services to evaluate, restore, and maintain competency to stand trial for adults and youth pursuant to §19.2-169.2, §16.1-356, and §16.1-357;
- Provide or arrange the provision of forensic evaluations required by local courts upon receipt of a court order; and
- Provide predischarge planning for persons found not guilty by reason of insanity, prepare conditional release plans, implement the court's conditional release orders, and submit progress and adjustment reports, pursuant to §19.2-182.2 through 182.7 and §19.2-182.11.

CSBs provide emergency services to local and regional jails and juvenile detention centers. Emergency services include evaluations and pre-screening for hospitalization. CSBs also conduct non-emergency evaluations, including evaluations of competency to stand trial, criminal responsibility, and waivers of juvenile court jurisdiction. Many CSBs also provide mental health and substance abuse services to the offender population through local initiatives developed jointly with local and regional jails and juvenile detention centers. These services include: individual and group mental health and substance abuse counseling; psychiatric services, including medication; and restoration to competency.

The Department uses federal SAPT block grant funds to support one substance abuse case manager in each CSB to identify cases and provide assessments and counseling. An initiative involving five CSBs provides substance assessment, case identification, crisis stabilization, and linkage to community programs after release for juveniles in detention centers. Nine CSBs receive funds to provide intensive substance abuse treatment patterned after offender-based therapeutic communities in segregated jail living areas.

CSBs also provide services through 10 adult and two juvenile drug courts to non-violent felons who are offered this as an alternative to incarceration and treatment in jail. Drug courts combine long-term (12-18 months), strict, frequent supervision by probation staff, intensive drug treatment by clinicians, and close judicial monitoring by the court.

State mental health facilities provide the following services to adult and juvenile offenders:

- Evaluation of competency to stand trial,
- Evaluation of criminal responsibility,
- Emergency inpatient treatment prior to trial,
- Treatment to restore competency to stand trail,
- Emergency treatment after conviction and prior to sentencing, and
- Emergency treatment after sentencing but prior to transfer to the Department of Corrections (DOC).

In FY 2000, approximately 25 percent of the patients in state mental health facilities were admitted from courts and jails or juvenile detention centers for treatment or evaluation. Of these, 12 percent had active status as pretrial or post sentence jail inmates and 13 percent were found not guilty by reason of insanity. In FY 2000, approximately 400 adult jail inmates and juvenile detention center residents were treated or evaluated in state mental health facilities. While there will always be a subgroup of jail residents who will need acute inpatient treatment, many inmates with mental health or substance abuse problems can be managed on-site, in jail settings, provided that the proper services are available in those locations.

During the early summer of 2001, the Department surveyed the CSBs for the period from November 1, 2000 to April 30, 2001 to obtain an estimate of the number of adult and youth offenders in jails and juvenile detention centers who received or who needed mental health or substance abuse services. Each CSB was asked to provide the following information for each jail and juvenile detention center that serves its catchment area.

Estimated service information for the survey period:

- Total number of individuals receiving certain services,
- Units of services received, and
- Estimated CSB expenses for services.

Projected services that are needed but not received:

- Estimated number of individuals needing certain services, and
- Estimated number of units of certain services needed.

Survey results from the 34 responding CSBs do not cover all jails or juvenile detention centers in Virginia. CSB jail survey data were provided on 55 (70 percent) of the 78 jails in the state,

representing 86 percent of the inmate populations during the reporting period. CSB juvenile detention center survey data represented 17 of the 22 juvenile detention centers statewide (77 percent). These juvenile detention centers served approximately 83 percent of the total juvenile detention center population resident during the survey period. Because data were not available for all facilities, statewide results represent estimates based on extrapolations from the sample data.

Responding CSBs projected that their expenses for mental health and substance abuse services that they provided or contracted for in jails during the six-month period to be $ 3.05 million and in juvenile detention centers to be $1.18 million. Results of the CSB surveys of local and regional jails and juvenile detention centers for the six month period follow.

Results of CSB Survey of Services Provided and Needed in Local and Regional Jails
November 1, 2000 through April 30, 2001

MH and SA Services Delivered by the CSB or CSB Contractor	Persons Served	Persons Needing Services Who Did Not Receive Them	Statewide Estimate of Unmet Service Needs	
			# Persons Needing Service	*# Units Needed*
MH Emergency	2,777	545	632	2,953
MH Outpatient Services	1,589	2,418	2,805	101,636
MH Medication Management	1,212	601	697	1,796
MH Case Management	951	1,637	1,899	5,665
MH Day Treatment	70	352	408	4,291
MH Rehabilitation	0	196	277	113,854
MH Other*	48	100	116	464
Unduplicated MH	4,226	4,092	4,747	
SA Emergency	225	129	150	377
SA Outpatient	4,547	2,346	2,721	16,116
SA Medication Management	60	103	119	223
SA Motivational Treatment	693	2,767	3,210	12,346
SA Case Management	471	2,102	2,438	13,941
SA Day Treatment	377	827	959	264,193
SA Other**	1,063	886	1,028	48,633
Unduplicated SA	5,369	6,124	7,104	

* MH "Other" services responses included family support group, mental health consultation and MH support

** SA "Other" services responses included aftercare support group, HIV/IV drug counseling, SA habilitation, therapeutic community, dual diagnosis treatment, HIV early intervention, HIV/IV drug education, and post-release group homes and mentoring.

Results of CSB Survey of Services Provided and Needed in Juvenile Detention Centers

November 1, 2000 through April 30, 2001

MH and SA Services Delivered by the CSB or CSB Contractor	Persons Served	Persons Needing Services Who Did Not Receive Them	Statewide Estimate of Unmet Service Needs	
			# Persons Needing Service	*# Units Needed*
MH Emergency	555	257	308	924
MH Outpatient Services	621	607	728	4,772
MH Medication Management	154	177	212	700
MH Case Management	370	230	276	1,154
MH Day Treatment	1	181	217	4,896
MH Rehabilitation	0	94	113	505
MH Other	0	30	36	43
Unduplicated MH	1,257	1,056	1,267	
SA Emergency	43	8	10	32
SA Outpatient	881	989	1,187	11,436
SA Medication Management	11	13	16	47
SA Motivational Treatment	8	756	907	4,327
SA Case Management	186	312	374	1,614
SA Day Treatment	0	48	58	1,507
SA Other	96	12	14	1,296
Unduplicated SA	1,174	1,609	1,931	

A number of CSBs (approximately 10) were only able to provide estimates of the number of persons served and units of services provided. This suggests the need for modifications to existing data systems to more accurately track the provision of jail services by CSBs.

Typically, CSBs would not know if someone was in need of these services unless a service request was made. Therefore, the numbers presented from this survey are likely to represent an underestimate of the actual services needed in jails and in juvenile detention centers. To obtain a more accurate picture of the number of inmates who need mental health or substance abuse services, a more comprehensive study would need to be undertaken.

In addition to service needs identified in the CSB surveys, the following issues related to the provision of forensic services have been identified by the Department:

- Statutory responsibilities for the provision of treatment services to adult and youth offenders are not defined. Currently, no entity at the state or local level has clear responsibility for the provision of these services to adult or youth offenders. The *Code of Virginia* does not stipulate that the jails are responsible for providing their own mental health and substance abuse services, as it does for the Department of Corrections. The *Code*, however, does require that sheriffs provide all necessary health care for jail inmates.

- Standards for what mental health and substance abuse services should be available to adult and youth offenders across Virginia are lacking, especially in areas of:
  - assessments to determine the presence of any mental illness, serious emotional disturbance, and substance dependence and abuse and the most appropriate service dispositions for specific offenders;
  - diversion services for nonviolent adult and youth offenders;
  - treatment services provided in jails and detention centers; and
  - post-release treatment services, including specialized services such as supervised living programs.
- Agreements between jails, detention centers, and CSBs for the delivery and coordination of services need to be strengthened. Enhanced coordination is needed among jails, detention centers, and CSBs in areas of pre-release planning, communications, and continuity of care to assure rapid connection to community services upon release.
- The capability of CSBs to provide restoration to competency services in jails and community settings should be enhanced.
- The Department's current Forensic Review Panel process is very centralized and slow. Consideration should be given to decentralizing the privilege-granting authority of the Forensic Review Panel to individual state facilities in a reasonable manner and with adequate oversight, in order to streamline the process required for progression to community placement for insanity acquittees.
- The process of managing insanity acquittees who have been conditionally released needs to be enhanced in order to prevent readmission of these consumers to state mental health facilities.

Persons Who Are Deaf, Hard-of-Hearing, Late Deafened, or Deafblind

In its *"Proposal for Mental Health Program for Persons Who Are Deaf, Deafblind or Hard of Hearing"* (1998), the Department's Advisory Council for Services for People Who Are Deaf, Hard-of-Hearing, Late Deafened, or DeafBlind (Advisory Council) notes that hearing loss affects 8.6 percent of the general population. Of this population, between five and 10 percent experience a vision loss in conjunction with their hearing loss. The document states that research generally suggests that the prevalence rates for serious mental illness within the deaf, hard-of-hearing, late deafened, and deafblind population are consistent with those found in the general population but that some studies suggest higher prevalence rates for adjustment and personality disorders, emotional or behavioral dysfunction, and substance abuse. The documents suggests that "Contributing factors to this may include isolation due to communication barriers, lack of family support (80 percent of deaf children who use a signed language do not have one parent who becomes fluent in that language), underemployment, late onset of hearing loss, and lack of social identification" (page 2). The Advisory Council concluded that this communication barrier also prevents access to traditional CSB programs, resulting in the need for specialized and accommodated services for this population.

The Advisory Council, which is composed of service providers and state agency representatives, is charged with assessing critical needs for this population, providing service oversight, and recommending future direction for service improvements and development in all three disability areas. In its 1998 document, the Advisory Council identified the following gaps that exist in Virginia's services system.

- Fragmentation and lack of continuity in the spectrum of services available resulting from the lack of state-level coordination;
- Significant difficulties experience by the regional programs, including inadequate regional program staff to projected target population ratios and the large size and diversity of each region;
- Programmatic gaps and restricted accessibility to the full range of CSB services statewide, particularly in areas of substance abuse treatment, residential programs, emergency services, child and adolescent services, and interpreter services.
- Insufficient input by consumers, family and advocacy organizations for deaf, hard-of-hearing, late deafened, and deafblind persons into the development of services at the local, regional, and state levels.

To meet the challenge of serving individuals who are deaf, hard-of-hearing, late deafened, and deafblind this document proposed a model service system and made the following recommendations.

- Establishing a full-time State Coordinator of Mental Health Services for the Deaf, Hard-of-Hearing, Late Deafened, and DeafBlind;
- Expanding regional community-based programs;
- Establishing a video-teleconferencing capacity at the Western State Hospital Deaf Unit;
- Enhancing community-based services such as interpreter services, assistive listening devices, and staff training;
- Developing specialized substance abuse, residential, emergency, and child and adolescent services;
- Increasing opportunities for consumer and family involvement; and
- Supporting a network of cooperative alliances between agencies with responsibilities for serving individuals who are deaf, hard-of-hearing, late deafened, and deafblind (pages 6-14).

The Department established a full-time State Coordinator position in 1999 to staff the Advisory Council and to provide technical assistance and support necessary to:

- improve the capacity of the service system to address the communication and cultural access needs of this special population and
- develop and improve access to needed specialized resources, professionals, support services, and technical assistance on a regional basis.

In addition to providing technical assistance and consultation, the first two years of State Coordinator activity focused on role clarification, gathering data on existing programs, and laying the groundwork for future service and policy activities. This work has resulted in the identification of the following issues requiring attention during the next three biennia.

- State facilities and CSBs need guidance in how to appropriately address the communication and cultural needs of this population.
- Regional programs and other community-based services need additional resources to meet the service needs of this population.

- Consumers and family members need a greater voice and involvement in service delivery planning and development.

Goals, Objectives, and Strategies

Goal: Provide a statewide safety net of short-term intensive intervention community services for all individuals who experience a crisis due to their mental disability or addiction to or abuse of alcohol or other drugs.

Objectives:

1. Foster development of a full menu of community-based short-term intensive intervention services with statewide accessibility.

Strategies:

a. Review the various types of community-based short-term intensive intervention services that are being used in other states and examine their effectiveness in reducing those states' reliance upon state facility services in FY 2003.

b. Seek resources to fill existing gaps in the array of community-based intensive intervention services.

c. Continue to work with CSBs, the Virginia Hospital and Healthcare Association, the Supreme Court of Virginia, the Psychiatric Society of Virginia, and the College of Emergency Physicians to identify and resolve issues affecting the delivery of emergency services and acute inpatient care.

Goal: Develop a full menu of longer-term mental health, mental retardation, and substance addiction and abuse services that promote recovery, rehabilitation, employability, and self-determination for those individuals who require such longer-term services.

Objectives:

1. Foster development of a full menu of longer-term mental health, mental retardation and substance addiction and abuse services.

Strategies:

a. Address demand documented by CSBs for individuals on CSB waiting lists for longer-term services as part of the agency's biennium budget submissions.

b. Seek resources to develop longer-term community services required by individuals who have been identified as ready for discharge (MH) and by individuals or their legally authorized representatives who choose to be discharged (MR).

c. Work with CSBs, private health care providers, and other provider organizations to increase the pool of private longer-term services providers during FY 2003 and FY 2004.

Goal: Expand the role of prevention within the continuum of substance abuse services.

Objectives:

1. Expand and enhance prevention programming for high-risk youth and their families by developing resources and support processes for selective and indicated prevention services.

Strategies:

a. Supply services providers with information on science-based prevention practices and technical assistance in the implementation of these practices.

b. Seek resources to increase the availability of science-based prevention services known to reduce abuse and addiction rates in children, youth, young adults, and adults.

c. Continue and enhance a system of support for local and state prevention planning and accountability.

d. Monitor the use of SAPT block grant and other funds supporting prevention services through planning process reports, the Performance Based Prevention System (PBPS) database, and quarterly performance contract reports from CSBs.

e. Collaborate with federal and other state systems and participate in national and state organizations focusing on prevention to increase service scope and effectiveness.

Goal: Reduce the incidence and prevalence of youth suicide in Virginia.

Objectives:

1. Increase the capacity of and expand comprehensive mental health youth suicide prevention services for children and youth.

Strategies:

a. Develop and conduct a youth suicide needs assessment designed to target mental health clinicians and providers, residential and group home mental health workers, family preservation and child protective service workers, foster care workers, and crisis center personnel during FY 2003.

b. Provide clinical training to identified child-serving personnel.

c. Continue to coordinate suicide prevention activities with the Department of Education, Department of Health, and the Commission on Youth.

d. Collect measurable data regarding the incidence and prevalence of suicide attempts and suicide completions in Virginia, beginning in FY 2003.

e. Develop information that is designed to increase the ability of mental health care providers to recognize and treat depression, substance abuse, and other mental illnesses associated with suicide risk in FY 2003.

f. Develop and promote Childhood Depression Awareness Day in May (National Mental Health Awareness Month) and provide accompanying materials.

g. Work to increase community-based intervention services and survivor support groups.

h. Develop and distribute resource materials and information links on the Department's website.

Goal: Promote an integrated and effective approach to preventing youth access to tobacco products.

Objectives:

1. Demonstrate compliance with state and federal SAPT block grant requirements prohibiting the sale or distribution of tobacco products to youth under the age of 18.

Strategies:

a. Work closely with the Department of Alcoholic Beverage Control to conduct inspections of an acceptable number of retailers.

b. Work with the Department of Health and the Tobacco Settlement Foundation to develop integrated public education campaigns.

c. Work with the CSBs to develop and implement locally-based strategies to prevent youth access to tobacco.

Goal: Promote the development of a comprehensive array of specialized prevention and treatment services and supports for elderly persons with mental disorders and substance dependence or abuse.

Objectives:

1. Explore the feasibility of establishing alternative community residential gero-psychiatric services in an effort to divert admissions to state geriatric mental health facilities.

Strategies:

a. Continue to convene the Department's gero-psychiatry panel to discuss, review, and evaluate proposed models of community gero-psychiatric programming during FY 2003.

b. Calculate admission rates to state mental health facilities in FY 2003 for patients from nursing homes whose admissions resulted from the inability of community providers to effectively manage defined targeted behaviors, such as wandering and aggressive behaviors, which routinely result in expulsion from nursing homes.

c. Develop a proposal in FY 2004 with recommendations for implementing a residential gero-psychiatric pilot program or programs that will test and monitor outcome measures on a limited scale and allow for comparative analysis among various residential models, such as a nursing home with a dedicated wing or a separate residential facility.

d. Depending upon the outcome of the pilot program or programs, work with the Department of Medical Assistance Services, the nursing home industry, and the teaching hospitals to develop community gero-psychiatric residential services and address the shortage of geriatric psychiatrists.

e. Promulgate standards for the licensing of community residential gero-psychiatric services.

2. Expand expertise in adapting psychosocial rehabilitation to gero-psychiatric patients throughout the state mental health facilities.

Strategies:

a. Establish a collaborative team in FY 2002 with Catawba Hospital, Piedmont Geriatric Hospital, Southwestern Virginia Mental Health Institute, and Eastern State Hospital staff to develop, adapt, and share psychosocial rehabilitation processes that recognize the unique nature and challenges of the geriatric population.

b. Continue to provide consultation and training to the state mental health facilities and to the providers of specialized gero-psychiatric inpatient treatment and care.

c. Develop and implement processes throughout the state mental health facilities that are consistent with psychosocial rehabilitation elements but are adapted to meet the unique

challenges posed by this population in FY 2003.

d. Facilitate the networking of state mental health facilities with facilities in other states that have demonstrated expertise in designing and adapting psychosocial rehabilitation processes with similar challenging populations.

3. Develop a comprehensive, community-based continuum of mental health, mental retardation, and substance abuse services for older Virginians.

Strategies:

a. Work with CSBs, community providers of aging services, and community senior organizations to raise their awareness of the mental health, mental retardation, and substance abuse service needs of older Virginians.

b. Work with CSBs and aging agencies to gather data on Virginians with mental illness, mental retardation, and substance abuse or dependency who are over 55, including their current living arrangements, and consolidate this information in FY 2003 into a report on older Virginians with disabilities.

c. Provide technical assistance and training on service models that respond to the mental health, mental retardation, and substance abuse needs of older Virginians.

d. Explore potential financial resources for the development of consumer-centered, family-focused community-based services that reflect best practices.

e. Work with the Department of Medical Assistance Services to establish a support model for older individuals receiving MR Waiver services.

f. Assist residential programs to develop and offer a support model for older individuals that allows them to "age in plan" without being required to move to a separate residence.

4. Increase awareness about the effects of prescription and other drug and alcohol use, abuse, and addiction on older adults and the adverse effects of the chronic administration of psychoactive substances to older adults.

Strategies:

a. Provide information to substance abuse treatment providers, primary care clinicians, social workers, senior center staff, and other service providers who have regular contact with older adults on the increased potential for prescription and over-the-counter drugs to interact with alcohol and illicit drugs.

b. Provide information to substance abuse treatment providers, primary care clinicians, social workers, senior center staff, and other service providers who have regular contact with older adults on appropriate periodic and routine screening, assessment, and referral procedures for age-appropriate substance abuse treatment services.

Goal: Promote the establishment of an integrated system of service delivery that is responsive to the mental health, mental retardation, and substance abuse needs of children and adolescents and their families.

Objectives:

1. Develop an integrated policy and plan that provides a framework and action steps for improving access by children and adolescents to mental health, mental retardation, and substance abuse services.

Strategies:

a. Continue to collaborate with agencies that have statutory responsibility for serving children, adolescents, and their families.

b. Review and compile in FY 2002 service information from child-serving state agencies on the mental health, mental retardation, and substance abuse needs of children and adolescents they serve.

c. Assess the availability of services currently provided by child-serving state agencies to address the mental health, mental retardation, and substance abuse needs of children and adolescents they serve in FY 2002.

d. Organize a workgroup of key stakeholders to make recommendations on improvements to the provision of and access by children and adolescents to mental health, mental retardation, and substance abuse services in FY 2002.

e. Develop and implement action steps aimed at improving access across all child-serving agencies to child and adolescent mental health, mental retardation, and substance abuse services, beginning in FY 2003.

Goal: Improve the quality and appropriateness of support and treatment for persons with a diagnosis of mental retardation and co-occurring mental illness.

Objectives:

1. ***Develop and implement best practice service models in Virginia for persons with a diagnosis of mental retardation and co-occurring mental illness.***

   Strategies:

   a. Seek expert consultations in FY 2002 from the National Association on Dual Diagnosis on models for addressing the needs of individuals with a diagnosis of mental retardation and co-occurring mental illness.

   b. Provide joint training for state facility and community administrators, clinicians and direct care workers aimed at identifying and appropriately responding to the needs of individuals who may have a dual diagnosis, clarifying service responsibilities, and reconciling differences in language, philosophy, and expected outcomes between mental health and mental retardation services providers.

   c. Continue to work with the Department's MI/MR Task Force, comprised of state facility and community program representatives, to develop best practices in Virginia.

   d. Develop a plan, in collaboration with state mental health and mental retardation facilities and community public and private mental health and mental retardation services providers, to implement best practices in community and state facility settings beginning in FY 2003.

   e. Provide technical assistance and training to state facilities and community public and private providers on steps necessary to implement best practices.

2. ***Provide training for psychiatrists, family practitioners, clinical psychologists, nurse practitioners, physician's assistants, and other clinical staff on psychiatric issues for persons with developmental disabilities.***

Strategies:

a. Arrange for national experts, such as the Community Circle in Denver, to conduct training sessions for Virginia practitioners in FY 2002.

Goal: Support the development of a systemic treatment infrastructure that ensures a continuum of services that include interventions that are appropriate for individuals with opioid addictions.

Objectives:

1. Develop and implement best practice service models in Virginia for individuals who are addicted to opioids and are seeking services.

Strategies:

a. Sponsor workshops and conferences for substance abuse program directors and treatment staff that focus on best practice treatment models in FY 2003.

b. Provide assistance to CSBs in framing strategies for developing and implementing opioid treatment services that reflect evidence-based best practice models.

Goal: Enhance Virginia's capacity to provide forensic evaluation and mental health and substance abuse treatment services to individuals involved with the criminal justice system.

Objectives:

1. Define, in collaboration with the Department of Criminal Justice Services, Department of Juvenile Justice, and Department of Corrections, the continuum of mental health and substance abuse services that should be available to adult and youth offenders.

Strategies:

a. Seek assistance from national experts, staff of jails and juvenile detention centers, sheriffs, CSBs and other local treatment providers, and mental health and substance abuse advocacy organizations in the definition of this continuum during FY 2003.

b. Incorporate into this continuum national and state services models that represent best practices in areas such as crisis teams, assessments and diagnostic services, early identification procedures, treatment services, pre-release planning, assertive case management, post-release services, and drug courts.

c. Develop an interagency long-range plan to implement this continuum of services statewide, beginning in FY 2004.

d. Identify and, where appropriate, seek funding to address gaps in the continuum of essential services.

2. Strengthen state and local collaboration necessary to provide an effective continuum of care for adult and youth offenders with mental illnesses and substance abuse service needs.

Strategies:

a. Collaborate with the Department of Criminal Justice Services, Department of Juvenile Justice, and Department of Corrections in ongoing strategic planning, policy

development, reporting of consistent and verifiable information on mental health and substance abuse services provided and needed, and budget planning for adult and youth offender populations.

b. Provide technical assistance to CSBs, jails and detention centers, sheriffs, and courts in the development and review of meaningful local memoranda of agreement that clarify goals, define responsibilities, and outline specific activities and tasks, including procedures for accessing treatment in jails and identification of case managers who are responsible for coordinating continuity of care across the systems.

c. Provide training in mental illness and substance abuse to criminal justice professionals and train mental health and substance abuse professionals in criminal justice issues.

d. Develop procedures for use by community agencies and jails and juvenile detention centers to initiate benefit applications and arrange for other community services and supports for inmates prior to their release.

e. Implement interagency initiatives as resources become available.

3. Provide forensic evaluation and treatment services in the most appropriate settings that meet but do not exceed the level of intervention or time frame necessary to provide necessary treatment and maintain public safety.

Strategies:

a. Continue to work with CSBs to expand their capacity to provide forensic evaluation services in the community.

b. Provide training and technical assistance to CSBs in FY 2003 to enhance their management of insanity acquittees who have been conditionally released.

c. Decentralize a portion of the Department's Forensic Review Panel privilege-granting authority to individual facility internal review panels for state facility forensic patients who meet certain criteria in FY 2003.

Goal: Ensure quality and continuity of care for people who are deaf, hard of hearing, late deafened, or deafblind and are in need of mental health, mental retardation and substance abuse services.

Objectives:

1. Strengthen existing policies and guidelines at state facilities and CSBs to promote access for people who are deaf, hard-of-hearing, late deafened, and deafblind to needed services.

Strategies:

a. Include instructions regarding communication and culturally affirmative language in the FY 2003 community services performance contracts with CSBs.

b. Provide technical assistance and guidance on appropriate communication and cultural access to services for people who are deaf, hard-of-hearing, late deafened, and deafblind to CSBs and state facilities.

c. Create and disseminate in FY 2002 a resource guide to emergency services and other CSB staff.

d. Revise the existing Departmental Instruction in FY 2002 to specifically address the communication and cultural needs of this special population in state facilities.

e. Explore with the Advisory Council ways that the services system can appropriately refer individuals to culturally competent community and inpatient providers.

2. Assess performance and capacity at existing specialized programs serving people who are deaf, hard-of-hearing, late deafened, or deafblind.

Strategies:

a. Track Regional Coordinator caseloads through quarterly reports.

b. Track interpreter usage at the CSBs through the Interpreter Reimbursement Fund utilization.

c. Identify and assess the admission and discharge patterns of the Hampton/Newport News day and residential program and the Mental Health Center for the Deaf at Western State Hospital in FY 2002-2003.

d. Train regional coordinators and other specialists on assessing consumer substance abuse issues for appropriate referral for services.

e. Train interpreters to improve performance in the substance abuse services milieu.

3. Identify additional resources to meet the service demand of the deaf, hard-of-hearing, late deafened, or deafblind population.

Strategies:

a. Identify and confirm sites and funding sources, in consultation with the Advisory Council, for two additional regional coordination positions in the state, potentially in the Danville and Fredericksburg areas.

b. Identify, in consultation with the Advisory Council, current local service gaps and needs, with particular emphasis on updating the service needs identified in the Council's 1998 proposal and documenting the need for specialized mental health and mental retardation case management services.

c. Apply for Federal and state service and training funding, in cooperation with existing systems of care, to establish regional specialized services for children and adolescents.

d. Apply for Federal and state service and training funding, in cooperation with existing systems of care, to establish regional specialized substance abuse services.

e. Establish, through Federal funding, existing Department funds, and cooperative agreements among existing community providers, video-teleconferencing capability as a viable method of providing specialized care within each region.

f. Determine, with the Advisory Council, how the Interpreter Reimbursement Fund guidelines should be revised to ensure interpreter use where it is most needed in the community.

g. Work with CSBs, Regional Deaf Services Programs, and the Mental Health Center for the Deaf to evaluate admission and discharge data from specialized programs, to:
   - Identify where individuals who are discharged live in the community;
   - Assess the need for existing program enhancements; and
   - Determine the need for additional community-based supports at the local and regional levels.

h. Identify and implement, in consultation with the Advisory Council, approaches to

provide periodic updates on service availability and changes to members of the deaf, hard-of-hearing, late deafened, and deafblind community.

4. Increase the involvement of consumers who are deaf, hard-of-hearing, late deafened, or deafblind and their family members in service delivery planning and development.

Strategies:

a. Establish a Consumer and Family Involvement initiative for consumers who are deaf, hard-of-hearing, late deafened, or deafblind and their family members with the Department's Office of Consumer Affairs.

b. Provide training to enhance the cultural competence of the regional providers to improve their capacity to involve consumers and their family members in meaningful ways.

c. Provide regional technical assistance in recruiting and involving consumers and family members in regional dialogues.

d. Collaborate with the Advisory Council to recruit consumers and family members for participation in its statewide planning efforts.

e. Identify potential resources that could be used to continue this initiative beyond year one.

CONTINUITY OF STATE FACILITY AND COMMUNITY-BASED CARE

Preadmission Screening and Diversion

Continuity of care refers to the consistent, integrated, and seamless management of care among CSBs and state facilities to meet the needs of the individuals they serve and their families. Continuity of care is most critical at those points of interaction where community-based service providers and state facilities share responsibility for assisting the individual to make the transition from one service setting to another. The major activities related to these transitions are pre-admission screening, including medical screening; liaison activities; and discharge planning. The preadmission screening process is the first critical component of continuity of care.

Preadmission screening is performed by CSBs and it coordinates admission to inpatient psychiatric hospitals and verifies an individual's need for inpatient psychiatric care as defined by the *Code of Virginia* (§37.1-67.1). Preadmission screening provides a uniform method of entry into all state psychiatric hospitals, as required by the *Code of Virginia* (§§ 37.1-65, 37.1-67.3, and 37.1-197.1). Recent Departmental policy initiatives have focused on the role of the preadmission screening process to ensure:

- The clinical appropriateness of treatment choices through clinical assessments required prior to admission, e.g. medical screening and assessments, substance abuse screening, assessment of mental status, and assessment of risk;
- Evaluation of the potential medical treatment needs of all individuals who present for admission to state psychiatric hospitals;
- Identification of less restrictive community-based treatment alternatives; and
- Enhanced collaboration among local stakeholders in the provision of emergency mental health services.

State psychiatric hospitals and training centers are structured to provide treatment and

habilitation services for persons with serious mental illness and mental retardation. Individuals with other related disorders are, through the prescreening process, referred to more appropriate treatment settings with the capacity to meet their specific needs. To ensure appropriate utilization of state psychiatric facilities, the Department has identified in the community service performance contract the following populations for whom state hospital admission is inappropriate.

- Individuals with unstable medical conditions that require extensive medical or detoxification services;
- Individuals who have behaviors that are due to medical disorders, neurological disorders (including head injury), and mental retardation and who do not have a qualifying psychiatric diagnosis or serious emotional disturbance;
- Individuals with primary diagnoses of adjustment disorder, antisocial personality disorder, or conduct disorder;
- Individuals with a diagnosis of dementia, as defined in the Diagnostic and Statistical manual, unless they also have significant behavioral problems, as determined by qualified state facility staff; and
- Individuals with primary diagnosis of substance abuse.

In addition to delineating specific populations for whom treatment in state psychiatric hospitals is inappropriate, the Department has incorporated requirements and procedures in the community services performance contract that address admission criteria and the prescreening services and assessments required prior to admission, e.g. medical screening and assessments, substance abuse screening, assessment of mental status, and assessment of risk. The Department also recently issued a clarification regarding medical screening and assessment expectations for individuals being admitted to state psychiatric hospitals or institutes.

Further, the Department has developed a new Uniform Preadmission Screening Form, disseminated the Procedural Expectations for Preadmission Screening, and developed related training materials for CSB Preadmission Screening Evaluator Certification Training. The *Code of Virginia* mandated that by January 1, 1999, all CSB preadmission screening evaluators complete a certification training program approved by the Department. The training has ten core areas and establishes minimum qualifications for prescreening evaluators. Additionally, professional videotapes and a corresponding *Preadmission Screening Evaluator Certification Training Manual* have been developed and distributed to all CSBs. Core areas for which standardized training has been developed include: Capacity to Consent to Treatment, Risk Assessment, Applicable Statutory Provisions of the *Code of Virginia*, Procedural Expectations for Preadmission Screening Evaluators and Use of the Uniform Preadmission Screening Form, Continuity of Care Procedures, Clinical Evaluation and the Mental Status Exam, and Psychotropic Medications.

With respect to medical screening, the Department recognizes that persons with serious psychiatric illnesses or severe mental retardation may have coexisting non-psychiatric medical disorders that require treatment before the person may be successfully treated for their psychiatric condition or mental retardation. These conditions may, in fact, complicate symptomatic presentation of the individual's mental disorder, represent severe disease requiring urgent treatment, or account for the symptoms leading to the referral for admission to a state-operated hospital. The Department will continue to emphasize the importance of medical screening, assessment, and provision of treatment in a timely fashion and in a treatment setting that is

structured to provide needed medical services. The Department recently issued guidance to clarify expectations regarding medical screening and assessment for individuals being admitted to state psychiatric hospitals.

Finally, the Department will continue to emphasize and explore community mental health treatment alternatives, such as crisis stabilization, that are less restrictive alternatives to inpatient care and to encourage enhanced communication, problem solving, and planning among all stakeholders involved in the delivery of emergency services at the local level.

In 1998, the Department initiated three regional substance abuse census diversion projects to reduce primary substance abuse admissions to Southern Virginia Mental Health Institute, Southwestern Virginia Mental Health Institute, and Central State Hospital. This initiative has been expanded to include admissions to Western State Hospital and to conform an existing project diverting primary substance abuse admissions from Eastern State Hospital. These census diversion projects now include 35 of the 40 CSBs. Participating CSBs receive $3,095,809 in state and federal block grant dollars. These projects have resulted in a reduction of over 10,000 state mental health facility bed days from 1998 baseline levels. Northern Virginia is the only region that is currently not engaged in a primary substance abuse diversion project.

In September 1999, the Region IV (Central Virginia) Acute Care Project was established to provide acute psychiatric care in local hospitals. The project relies on local bed purchases that are managed by a regional structure that includes CSB, state facility, and Department utilization management staff. Since this project began, Central State Hospital has been able to close its civil acute admission unit and the project has served 753 patients in local hospitals. The average length of stay for these individuals has declined to 5.5 days. In FY 2001, only six patients were admitted to Central State Hospital through the project for long-term care.

The Region V (Eastern Virginia) CSBs have proposed a regional Plan for Community and Inpatient Care to expand community services capacity of individual CSBs and enhance access to acute care resources through a pre-paid contract with a community provider or providers for 20 new psychiatric beds reserved for CSB use for medically indigent individuals needing acute psychiatric care. Day to day management of these 20 new beds would be through a regional structure similar to that used for the Region IV Acute Care Project. The CSBs also would expand crisis stabilization services and individual CSB acute bed purchases in addition to the 20 new beds. By increasing the number of acute psychiatric beds available to the region, the CSBs hope to stabilize demand for Eastern State Hospital's acute admissions beds.

The three Southside CSBs served by Southern Virginia Mental Health Institute (SVMHI), Danville-Pittsylvania Community Services, Piedmont Community Services and Southside CSB, are proposing a Southern Virginia regional services plan to expand their capacity to purchase or develop local acute and other community-based psychiatric services, thereby reducing admissions to SVMHI by approximately 50 percent and eliminating diversions of Southern Virginia patients to other state hospitals. One component of this initiative would establish a residential program to divert inpatient admissions.

The Department's statewide contracts with community hospitals for acute psychiatric bed purchases are renewable annually for five years. Each year, local hospitals may increase the per diem and the physician charge (if any) up to the CPI for that year. These increases affect the Region IV Acute Care Project, the Discharge and Diversion Services (DAD) project in Northern

Virginia, and several other state mental health facilities that purchase local acute psychiatric beds when state facility beds are not available. There are three one-year renewable periods remaining on the current state bed purchase contract. Additional funds will be needed to adjust contracts with local hospitals based on the annual CPI.

An expanded array of short-term intensive intervention services includes some services, such as residential crisis stabilization programs and acute partial or day hospitalization, that are not widely developed in Virginia communities. CSBs participating in the Region IV Acute Care Project are proposing to create an eight-bed residential crisis stabilization program as part of the Acute Care Project. A similar proposal has been developed in Region I (Northwestern Virginia). These proposals recognize that many persons, who are presently referred to acute inpatient settings when they experience psychiatric crisis, could in fact be treated more appropriately in less-intensive and less-restrictive sub-acute but highly intensive residential settings.

If these proposals were implemented, Virginia would be able to reduce demand for acute short-term hospitalization at selected state mental health facilities and eliminate diversions of individuals to out-of-service area state facilities. Patients would be treated closer to home, with increased family involvement and enhanced continuity of care. Costs of additional travel associated with out-of-area hospitalizations by CSB staff, sheriffs, and family members also would be reduced.

In an ongoing effort to improve communication and coordination in the delivery of emergency services, the Department is participating in a workgroup of stakeholders, including CSBs, state facilities, the Virginia Hospital and Healthcare Association, the College of Emergency Room Physicians, the Virginia Psychiatric Society, judicial officials and law enforcement personnel. This group will review the effectiveness of preadmission screening and emergency services practices and respond to the following ongoing concerns:

- Standardization in local preadmission screening practices is lacking;
- Collaboration among local stakeholders varies considerably and roles may be confused and ill-defined;
- Medical screening, assessment, and treatment is not uniformly available or provided for individuals seeking admission to state psychiatric hospitals; and
- Standardized training resources for all core training areas of the certification process for preadmission screeners have not yet been developed and disseminated. Additionally, mechanisms to monitor compliance with the mandatory certification training program have not yet been established.

Discharge Planning

Section 37.1-197.1 of the *Code of Virginia* requires CSBs to provide, in consultation with the appropriate state mental health or mental retardation facility, predischarge planning for any person who, prior to admission, resided in a city or county served by the CSB or who chooses to reside there after being discharged from a state facility. Section 37.1-197.1 further requires that the predischarge plan:

- be completed before the person's discharge;
- be prepared with the involvement and participation of the person or his representative;

- reflect the person's preferences to the greatest extent possible;
- include the mental health, mental retardation, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services that the person will need upon discharge into the community; and
- identify the public and private agencies that have agreed to provide these services.

Section 37.1-98 of the *Code of Virginia* authorizes a state facility director to discharge a person, who has been determined to be clinically ready for discharge from a state mental health facility or who has chosen to be discharged from a state mental retardation facility, after a predischarge plan has been prepared in accordance with the provisions of §37.1-197.1 of the *Code of Virginia*. Section 37.1-198 of the *Code* establishes the community services performance contract as the mechanism through which the Department provides funds to the 40 CSBs to accomplish the purposes set forth in Chapter 10 of Title 37.1 of the *Code of Virginia*.

The Department initiated efforts to improve and enhance predischarge planning activities of the CSBs and state facilities in an August 25, 2000 memorandum, which reiterated statutory and performance contract responsibilities and expectations regarding predischarge planning. This memo also required state facilities and CSBs to develop procedures to comply with those provisions and to prepare reports documenting the movement of consumers from state facilities to communities. While these initial efforts yielded some increased consistency and improvements, there was a general recognition that more needed to be done and the need for uniform statewide predischarge planning protocols was raised with the System Leadership Council.

In the winter of 2000 and early spring of 2001, the Department's DOJ consultants provided instruction to CSB representatives and state facility treatment team members at the Northern Virginia Mental Health Institute, Central State Hospital, and Western State Hospital in the "needs-based" discharge model. This training was intended to clarify the roles of parties involved in discharge planning related to client needs identification and community resource identification. This training will be replicated in all other state mental health facilities and will be expanded for its concurrent value to the state training centers.

Sections 5.3.3 and 9.9 of the FY 2002 performance contract require CSBs and the Department to work cooperatively to develop uniform statewide predischarge planning protocols by December 1, 2001. Subsequently, these protocols will become part of that contract, thorough an amendment. The System Leadership Council, established pursuant to provisions in the FY 2001 community services performance contract, agreed that a small work group of knowledgeable individuals should develop predischarge protocols for state mental health facilities and training centers. The Department established a Steering Committee in May of 2001 to assist in developing these protocols. The Steering Committee included representatives of CSBs, state facilities, and the Department's Central Office. Department staff developed initial drafts of the protocols, reflecting statutory requirements, performance contract provisions, and experience with efforts resulting from the August 25, 2000 memorandum and distributed the drafts to the Steering Committee before its first meeting. The Steering Committee established two separate work groups with clinical staff representation to further refine the draft mental health and mental retardation discharge planning protocols. Following a review of draft predischarge planning protocols by the CSB executive directors and state facility directors, Department staff revised the drafts for review by the Steering Committee. Following that review, the Department distributed

exposure drafts of the protocols for review and comment to CSB executive directors, state facility directors, State Board members, Department staff, and consumer and family advocacy organizations. The Steering Committee reviewed comments and made final revisions of the protocols. The Department distributed final versions of the protocols to CSB chairmen and executive directors, state facility directors, State Board members, and advocacy organizations on November 5, 2001.

The final versions of these discharge planning protocols reflected extensive review and comment activities and the best professional judgment available across Virginia. The protocols provide clear expectations and a consistent platform across all CSBs and state facilities for the services system's predischarge planning efforts. They will support the greatest degree of consistency or uniformity in predischarge planning practices across Virginia, while still permitting appropriate operational flexibility locally. The protocols will clearly define state facility and CSB responsibilities, required communications, required and recommended practices, and applicable time frames in areas of:

- Admission to state facilities;
- Needs assessment and discharge planning;
- Individualized treatment planning;
- Readiness for discharge;
- Completion of the discharge process; and
- Transfer of case management CSB responsibilities.

The protocols also include disability-specific standardized formats for documenting an individual's needs upon discharge and his discharge plan.

Serving Individuals in the Most Integrated Setting Appropriate to Their Needs and Choices

The Americans with Disabilities Act (ADA) prohibits discrimination in public services furnished by governmental entities (Title II, 42 U.S.C. § 12131-12165). Title II regulations issued by the U. S. Attorney General included an integration regulation that states "A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." On June 22, 1999, the U.S. Supreme Court decided in Olmstead et al v. L.C. et al. that states are required under Title II of the ADA to provide community-based treatment for persons with mental disabilities when the:

- State's treatment professionals determine such placement is appropriate;
- Affected persons do not oppose such treatment; and
- Placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities.

The Olmstead decision does not prohibit institutional placement, but, in fact, recognizes it as the least restrictive setting for some individuals who cannot handle or benefit from community settings. Additionally, the decision affirms that there is no federal requirement that imposes community-based treatment of patients who do not desire it. Under the Olmstead decision, a state can demonstrate reasonable accommodation if it has in place:

- A comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and

- A waiting list that moves at a reasonable pace not controlled by the state's efforts to keep its institutions fully populated.

The State Facility Discharge Waiting List Data Base provides the following information about needed service availability and most frequently mentioned barriers to discharge for the 137 mental health facility patients identified as ready for discharge and the 256 training center residents who had chosen community services and supports as of June 20, 2001.

Summary of the Status of Identified Service Requirements in State Mental Health Facility Patients' Discharge Plans

June 30, 2001

Service	Service Is Currently Available at or Through the CSB	Service Is Not Currently Available	
		Additional Resources Would Be Required	*Lack of Providers Limits Service Availability Even With New Resources*
Outpatient Services			
Psychiatric Services	85	3	0
Medication Management Services	87	2	0
Assertive Community Treatment	13	5	4
Counseling and Psychotherapy	20	3	1
Behavior Management	7	2	1
Intensive SA Outpatient	4	2	0
Intensive In-Home	2	1	1
Case Management Services	76	2	0
Day Support Services			
Day Treatment/Partial Hospitalization	8	0	1
Rehabilitation	16	3	1
Therapeutic Day Treatment	4	1	0
Sheltered Employment	2	3	1
Supported Employment Group Model	2	3	1
Transitional or Supported Employment	5	5	2
Alternative Day Support Arrangements	6	3	0
Residential Services			
Highly Intensive	14	23	21
Intensive	9	7	5
Supervised	12	4	7
Supportive	7	1	1
Family Support	4	2	1

The following information describes those individuals who were identified as being ready for discharge from a state mental health facility on June 30, 2001.

- All but 13 of these individuals had been hospitalized for four months or longer, with 41

individuals hospitalized from four to 12 months, 47 individuals from 13-36 months, and 35 individuals for longer than 37 months.

- CSBs reported the following times that had elapsed since state mental health facility patients were placed on the facilities' discharge lists.
  - 24 individuals had remained on the discharge waiting list for less than one month,
  - 40 individuals had remained on the discharge waiting list from one to three months,
  - 51 individuals had remained on the discharge waiting list from four to 12 months,
  - 18 individuals had remained on the discharge waiting list from 13 to 36 months, and
  - 1 individual had remained on the discharge waiting list for more than 36 months.

  Three records did not provide this information.
- With respect to their anticipated discharge dates, CSBs projected that:
  - 32 individuals could be discharged in under one month,
  - 43 individuals could be discharged in one to two months,
  - 13 individuals could to be discharge in three to four months,
  - 11 individuals could be discharged in five to six months.

  For 8 individuals, the projected discharge date was longer than six months. An anticipated discharge date was not entered for 30 cases.
- A number of individuals were identified by the CSBs as having conditions or needs that could require specialized services and supports, among them:
  - High or extensive behavioral needs - 58 individuals,
  - Dementia - 38 individuals,
  - Major medical conditions or chronic health problems - 30 individuals, and
  - High or extensive physical or personal care needs - 23 individuals.

  Only 8 individuals were identified as having a forensic status.

Summary of the Status of Identified Service Requirements for State Training Center Residents Who Have Chosen Discharge to Community-Based Services and Supports

June 30, 2001

Service	Service Is Currently Available at or Through the CSB	Service Is Not Currently Available	
		Additional Resources Would Be Required	*Lack of Providers Limits Service Availability Even With New Resources*
Outpatient Services			
Psychiatric Services	42	8	0
Medication Management Services	68	24	1
Intensive In-Home	1	0	1
Behavior Management	61	25	27
Assertive Community Treatment	1	0	0
Case Management Services	215	16	0

Service	Service Is Currently Available at or Through the CSB	Service Is Not Currently Available	
		Additional Resources Would Be Required	*Lack of Providers Limits Service Availability Even With New Resources*
Day Support Services			
Rehabilitation	61	43	7
Therapeutic Day Treatment	1	1	0
Sheltered Employment	28	10	10
Supported Employment Group Model	2	1	2
Transitional or Supported Employment	4	0	0
Alternative Day Support Arrangements	35	34	34
Residential Services			
Highly Intensive	36	63	72
Intensive	31	29	33
Supervised	1	2	1
Family Support	1	0	0

The following information describes those individuals who were identified as choosing discharge to community services and supports on June 30, 2001.

- The vast majority of these training center residents (226) had been residing in a training center for over ten years. Sixteen had been residents for between six and 10 years and 10 had been residents between one and five years. Only two had been training center residents for less than one year.
- CSBs reported the following times that had elapsed since residents were placed on the training centers' discharge lists.
  - 4 individuals had remained on the discharge waiting list for less than one month,
  - 8 individuals had remained on the discharge waiting list from one to three months,
  - 146 individuals had remained on the discharge waiting list from four to 12 months,
  - 74 individuals had remained on the discharge waiting list from 13 to 36 months, and
  - 9 individuals had remained on the discharge waiting list for more than 36 months.

  Fifteen records did not provide this information.
- CSBs were generally unable to determine an anticipated discharge date. The projected discharge date was under six months for 44 residents and longer than six months for 70 residents. No projected date was provided for 142 individuals.
- For these individuals, CSBs identified a variety of conditions or needs that could require specialized services and supports, among them:
  - High or extensive physical or personal care needs - 128 individuals,
  - Unable to communicate with verbal speech - 114 individuals,
  - High or extensive behavioral needs - 96 individuals,
  - Major medical conditions or chronic health problems - 82 individuals,
  - Non-ambulatory or major difficulty in ambulation - 65 individuals, and

‘ Dual diagnosis (MR/MI) - 60 individuals.

Additional information about the characteristics of individuals on state facility discharge waiting lists is provided in Appendix F.

Each CSB also was asked to identify applicable barriers to discharge, other than service unavailability, for each individual on its state facility discharge waiting list. This identification was based upon the most recent assessment of the individual's needs and circumstances. The most frequently identified barriers to discharge follow.

Frequently Identified Barriers to Discharge

June 30, 2001

Barrier	Number of Individuals With Identified Barrier	
	MH	MR
Appropriate and affordable housing is not currently available	38	59
Social supports are limited or lacking	18	52
MR Waiver funding not currently available	0	60
Required application for Medicaid not complete	17	23
Required bed in a nursing facility is not currently available	37	4
Services not accessible due to specialized service needs	15	23
No guardian or legally authorized representative is available	11	17
Application for income assistance (SSI/SSDI, auxiliary grant) not complete	5	24
Required transportation arrangements not currently available	0	25
Required medical/physical health care services are not currently available	10	9
Does not qualify for public assistance (SSI/SSDI, auxiliary grant, Medicaid)	13	1
Required specialized dental care is not currently available	0	12
Legal issues not resolved	10	1
Required personal assistance is not currently available	2	8

The Department has incorporated the following strategies into its planning to respond to the Olmstead decision:

- Develop community alternatives to acute psychiatric care now provided in state mental health facilities, using the Region IV Acute Care Pilot as a model;
- Continue support for existing state facility census reduction and diversion projects;
- Fund and monitor individualized service plans for long-term state mental health facility patients who have been identified by CSBs as ready for discharge but whose special needs have prevented their placement in the community;
- Continue to use the Medicaid MR Waiver to fund individualized plans of care for state training center residents who, based on consumer and family choice, are determined to be ready for community placements; and
- Reduce waiting lists for an array of community mental health, mental retardation, and

substance abuse services, thereby avoiding unnecessary hospitalizations and allowing timely discharges for consumers.

Goals, Objectives, and Strategies

Goal: Ensure consideration of every individual's medical well-being prior to admission to a state hospital by enhancing uniformity of local preadmission screening practices and effective emergency mental health services delivery.

Objectives:

1. ***Increase coordination, continuity, communication and cooperation among the components that make up the local system of emergency mental health delivery.***

   Strategies:

   a. Survey the nature, extent and content of local emergency services plans in FY 2002.

   b. Continue to meet with local and statewide stakeholders to enhance communication, education and information-sharing.

   c. Encourage the development of written local emergency services plans and protocols for managing and treating psychiatric emergencies throughout CSB catchment areas.

2. ***Assure that individuals being evaluated for admission to state psychiatric hospitals receive quality medical care and treatment in the most appropriate setting.***

   Strategies:

   a. Revise the Departmental Instruction on preadmission medical screening in FY 2002 and require each state psychiatric facility to develop a policy consistent with the DI governing the procedures to be used to attempt to obtain a medical screening prior to admission.

   b. Consider developing and requiring completion of a Medical Screening Form as an addendum to the Uniform Preadmission Screening Form in FY 2003.

   c. Survey CSBs in FY 2003 to determine whether they have adequate local plans for obtaining medical assessments and treatment.

3. ***Develop and implement standardized statewide uniform preadmission screening protocols to ensure more consistent decisions related to the admission of individuals to state facilities.***

   Strategies:

   a. Conduct a qualitative review in FY 2003 of CSB prescreenings, using a standardized instrument that assesses clinical pertinence including axis formulation, presentation of symptoms, and behaviors leading to the encounter.

   b. Develop a set of principles for determining less restrictive approaches based on clinical findings and risk assessment in FY 2003.

   c. Use a collaborative process with input from system stakeholders to develop standardized statewide uniform preadmission screening protocols in FY 2003.

   d. Develop, in collaboration with CSBs, standards for working with the courts on the use of prescreening and the selection of less restrictive settings in FY 2004.

4. ***Develop refinements to the preadmission screening evaluator certification and training process.***

Strategies:

a. Continue to expand the complement of training materials to be used in the preadmission screener certification training process.

b. Develop standardized training materials in FY 2003 on human rights and crisis intervention with special populations, including individuals with dual diagnoses and persons who are deaf or hard-of-hearing or who have other sensory impairments.

c. Develop proposed mechanisms for assuring compliance with the certification training program in FY 2003.

d. Continue to work with the Statewide Emergency Services Training Task Force to identify and respond to emerging training needs and support the biennial statewide emergency services conference.

Goal: Promote the expansion of community-based alternatives for the provision of acute psychiatric care, including residential crisis stabilization services, that are not widely developed in Virginia communities.

Objectives:

1. ***Expand support to existing community-based projects that divert individuals from admission to state mental health facilities.***

Strategies:

a. Seek resources to enhance the Discharge Assistance and Diversion Project in Northern Virginia, the Region IV Acute Care Project, and the Substance Abuse Primary Care Diversion Project.

2. ***Develop the capacity of CSBs in selected regions to provide community-based acute psychiatric care and other services necessary to divert acute admissions to state mental health facilities.***

a. Seek resources to develop a regional capacity-building and acute inpatient psychiatric project in Eastern Virginia to stabilize admissions Eastern State Hospital and a regional capacity-building project in Southside Virginia to reduce Southern Virginia Mental Health Institute admissions.

b. Seek resources to expand the Region IV Acute Care Project to include a short-term crisis stabilization component and implement a crisis stabilization program in Region I.

Goal: Institute more comprehensive and consistent predischarge planning practices across the state to improve the quality of care for consumers, ensure the most appropriate and effective use of state facility care, and support implementation of and compliance with relevant provisions in § 37.1-98 and § 197.1 of the *Code of Virginia.*

Objectives:

1. ***Implement the Discharge Planning Protocols at all state facilities and CSBs in January 2002.***

Strategies:

a. Continue to support training by national experts across Virginia that outlines the responsibilities of state facilities and CSBs in the needs assessment and discharge planning process.

b. Conduct regional training for CSBs and state facilities on the protocols and reporting requirements.

c. Revise community services performance contracts and state facility director performance agreements to incorporate discharge planning protocols.

d. Assure that CSBs and state facilities take necessary steps to implement the discharge planning protocols prior to January 2002.

e. Develop and implement automated versions of the Discharge Planning Protocols in FY 2002.

f. Monitor the implementation of the discharge planning protocols to assure consistency in application and state facility and CSB compliance with protocol requirements.

2. Implement replicated training in "needs-based discharge planning" model in the state mental health facilities that have not received this training.

Strategies:

a. Develop the scope of services for the DOJ consultants to provide this training.

b. Analyze each facility's current discharge planning effort, including a review of current social work staffing, facility discharge policies and related forms, treatment team planning policies related to discharges, and any functioning treatment team meeting procedures.

c. Review each facility's total discharges between January and June 2001, including placement sites of individuals who have been discharged.

d. Monitor use of the "needs-based discharge" planning model after implementation in each facility.

e. Explore the value of replicating this training model in the state training centers.

CONSUMER AND FAMILY INVOLVEMENT, EDUCATION AND TRAINING

Office of Consumer Affairs

The Department's Office of Consumer Affairs was established in September 1999 with the appointment of a director charged with designing and implementing a comprehensive office that would serve and represent consumers and family members. As of March 1, 2000 the office was fully staffed with a Consumer Quality Care Line Coordinator and a Consumer and Family Involvement Educator. Since its creation, the Office has:

- Established the Office of Consumer Affairs Advisory Board with representatives from all major advocacy groups in all disciplines to advise the Commissioner and staff on strategies to increase consumer and family involvement in state facility and community programs. Approximately 75 percent of Board members are consumers and family members.
- Supported CSBs in providing training for consumers and family members in order to enhance their skills and abilities for participation on governing boards and other policy-making or

program development and evaluation committees.

- Held a "Networking Conference" to which all CSBs were invited. A network of offices of consumer affairs was established as a result of the conference. This network meets quarterly to share information, provide support, and further develop roles and functions.
- Developed and updated a Resource Library of books, videos and pamphlets available for lending to consumers, family members, and care givers.
- Provided seed money to the Virginia Human Services Training Center to train consumers as peer counselors and assisted in role transition issues for these individuals.
- Provided funding to the regional deaf services programs to identify and educate approximately 60 deaf and hard-of-hearing consumers and 60 family members regarding empowerment, networking, and recovery.
- Published and disseminated a newsletter covering topics of interest to consumers, family members, and providers at least twice a year.
- Designed and conducted five regional seminars on "Consumer and Family Involvement in Service Plan Development".

The Department's Office of Consumer Affairs has established a Consumer Quality Care Line that provides consumers, their families and representatives with a central point-of-contact to express concerns and make inquires about services they are receiving or how to access services. The scope is very broad and assistance is provided to consumers, family members, providers and citizens across Virginia. In FY 2000-2001, the Consumer Quality Care Line responded to 1,966 contacts. The Office also has established an agreement with Department of Rehabilitation Services to provide a job-readiness site for consumers. Currently, the Office has its third trainee who is assisting with the Consumer Quality Care Line. An Office of Consumer Affairs brochure and website help publicize its activities and enhance access to its services.

Consumer and Family Education Projects

The Virginia mental health system has been enhanced and improved through the involvement of well-informed consumers and their families. This has been and continues to be a priority of the Department. Federal Mental Health Block Grant funds are used to support numerous activities across the state to educate consumers and their families about mental illnesses and their treatments. These include: the Virginia Human Services Training Center ($47,673) to train consumers as peer counselors, National Alliance for the Mentally Ill (NAMI)-Virginia to provide statewide education to consumers and their families ($100,000), Parents and Children Coping Together (PACCT) to educate parents and caregivers of SED children across the state ($75,000), and in southwest Virginia the Family Support Services Project ($32,500) and the Southwest Virginia Consumer and Family Involvement Project ($42,500).

The Virginia Human Services Training Center is located at the Piedmont Virginia Community College with support from the Region Ten CSB. The training is a collaborative effort of the Department, CSBs, Department of Rehabilitation Services, and the community college. Communities nominate consumers to be trained in the skills needed to provide peer counseling back at their home CSB. Each year approximately 15 consumers are trained.

With block grant support, NAMI-Virginia conducts assessments of family education needs in Virginia and provides training across the state. Over 28 new or existing family education groups

were developed or supported to inform consumers and their families about mental illnesses and their treatments. Technical assistance was provided to 50 family education/support groups using programs such as Mutual Education, Support and Advocacy (MESA), NAMI's Family-to-Family, NAMI Texas's VISIONS, and the Wellness Recovery Action Program (WRAP).

Also with block grant support, PACCT has trained over 100 family members and care givers of children with serious emotional disturbance. Its Family Involvement Workshop provided information about the service system in Virginia and taught the skills needed to effectively access services for children in need. A Family Leadership train-the-trainer workshop was conducted to train family members in the skills needed to conduct their own Family Involvement Workshop. A toll-free telephone number has been maintained to provide information and referral for mental health services for children across the state. Quarterly newsletters concerning mental health services for SED children have been published and distributed across Virginia.

The Family Support Services Project was established to develop and assist family support groups with education, support and advocacy. This effort is directed to family members of those with serious mental illness and involves close collaboration with CSBs in the region and the Southwest Virginia Mental Health Institute. Project activities include a toll-free information and referral line and "Ask the Doctor" videoconferences between support groups and the Institute.

The Southwest Virginia Consumer and Family Involvement Project is a consumer-driven project, the purpose of which is to prepare persons suffering from mental illness to become meaningfully involved in the mental health system by providing education, advocacy and support. Project activities are aimed toward increased consumer and family participation in decision making and policy formation, in service planning, and in the delivery and evaluation of publicly-funded mental health services. These activities include the coordination of LEAP (Leadership-Empowerment-Advocacy Program) Training, MESA Training, Peer Counselor Training and Community Integration Groups.

In addition to the programs and activities described above, the Virginia Mental Health Planning Council has partnered with the Mental Health Association of Virginia (with $150,000 in support from a Center for Mental Health Service's Community Action Grant) to promote the best practice of formally training consumers to be members of boards and serve on policy making entities. Through the Consumer Education and Leadership Training (CELT) program, consumers from across the state have received specialized training in the skills needed to effectively represent consumer issues on boards and committees.

Substance Abuse Consumer Advocacy

Consumer advocacy for substance abuse services has been slow to develop due to stigma, shame and fear. The Substance Abuse and Addiction Recovery Alliance (SAARA) of Virginia, a grassroots advocacy organization, has recently made strong inroads in Virginia by establishing a number of local alliances. In addition, SAARA of Virginia has successfully competed for funding from the federal Center for Substance Abuse Treatment to establish a statewide alliance, SAARA of Virginia, to provide leadership and support for local alliances.

The mission of SAARA of Virginia is to celebrate, support, and advocate for the prevention of and recovery from substance abuse and addiction by promoting social, educational, legal, research, and health care resources and services to achieve effective, accountable, and accessible prevention, intervention, and treatment. Membership is open to individuals and organizations.

Immediate plans of SAARA of Virginia include providing training in advocacy skills and information about treatment resources.

Goals, Objectives, and Strategies

Goal: Provide a strong foundation for consumer and family involvement in all aspects of the service delivery system.

Objectives:

1. ***Maintain a statewide system that provides opportunities for consumers and family members to voice concerns and resolve issues.***

   Strategies:

   a. Continue to coordinate and resolve constituency issues that come to the Department through the Governor's Office, Secretary's Office, and correspondence.

   b. Continue to support and encourage an active Office of Consumer Affairs Advisory Board.

   c. Operate the Consumer Quality Care Line and maintain and distribute demographic and referral data for all contacts received.

2. ***Continue to support the development of consumer and family education and training regarding illnesses and treatments throughout the Commonwealth.***

   Strategies:

   a. Develop and support the provision of educational and training opportunities for consumers and family members.

   b. Solicit vendors to continue to assess the need for, develop, and implement consumer and family education projects across the state.

   c. Support SAARA in ongoing statewide efforts to provide training regarding effective advocacy strategies to consumers, families, and other persons affected by substance abuse or dependence.

   d. Continue to monitor the progress of consumer and family education projects supported by federal block grant funds through the Mental Health Planning Council.

3. ***Support consumer and family participation in policy development, program operations, and individual service planning.***

   Strategies:

   a. Work with consumer and family member advocacy groups and CSB staff to identify and nominate consumer and family members for participation in state and local policy making and operational activities.

   b. Work with and assist interested consumers and family members to develop the leadership skills needed to serve on CSB boards of directors.

   c. Promote the involvement of consumers and family members in planning and evaluating their individualized services.

4. ***Identify and link consumers and family members to appropriate resources.***

Strategies:

a. Maintain current information about available services and supports on the Department=s Office of Consumer Affairs website.

b. Disseminate information on programs, available resources, and services through the Office of Consumer Affairs newsletter.

c. Maintain a resource library and collect data on materials loaned.

d. Distribute brochures, pamphlets, and materials published by federal, state, and local agencies and collect data on materials distributed.

e. Use collected data for continuous quality improvement purposes.

SERVICE QUALITY, RESPONSIVENESS, AND EFFECTIVENESS

As Virginia's single state authority for mental health, mental retardation, and substance abuse services, one of the primary responsibilities of the Department is to assure and continually improve the quality, responsiveness, and effectiveness of community and state facility services. To achieve this, the Department emphasizes a variety of quality improvement and oversight activities, including protecting the human rights of individuals receiving services in state facilities and community programs, defining and supporting the implementation of clinical best practices, establishing uniform clinical and administrative guidelines, monitoring performance and outcomes, using performance and outcomes in quality improvement activities, and monitoring the quality of community and state facility services.

Protection of Individual Human Rights

The *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation and Substance Abuse Services* (12 VAC 35-115-10 et seq.) culminate years of effort by many individuals and became effective on November 21, 2001. This single set of regulations replaced the three sets of human rights regulations for the state facilities, community programs, and licensed private psychiatric hospitals.

The new human rights regulations expand upon the fundamental rights of individuals receiving mental health, mental retardation, and substance abuse services as detailed in § 37.1-84.1 of the *Code of Virginia*. The regulations recognize that individuals receiving services have a right to choice, full participation in decision-making, and clinically appropriate treatment. These regulations define the composition, role, and function of the Department's human rights system, including Local Human Rights Committees and the State Human Rights Committee. They establish time frames and clear procedures for resolving consumer complaints.

The new human rights regulations reflect recent *Code* changes aligning Department licensing to substantial compliance with specified human rights requirements. They require providers to report to the Department all abuse, neglect, deaths, and serious injuries and require the Department to make this aggregate data available to the public. The regulations also provide for monitoring, evaluation, enforcement, and sanctions for violations of human rights.

The new human rights regulations will affect over 200,000 consumers and 450 providers throughout the Commonwealth. Following the promulgation of these new regulations, the regional advocates will assume additional responsibility for providing comprehensive advocacy services to approximately 49 private psychiatric hospitals. All of these hospitals provide acute

services to highly vulnerable individuals who are often in crisis. These hospitals will need extensive training and assistance to come into compliance with the new regulations.

An implementation schedule was provided to each of these providers in October 2001, detailing plans for monitoring compliance with the new regulations. The Department also assembled a Human Rights Training and Implementation Advisory Team to advise on training and implementation strategies for all providers. Regional external training will be provided in collaboration with the University of Virginia Institute of Law, Public Policy and Psychiatry after the promulgation process is completed.

Promotion of Quality of Care in State Facilities and Community Programs

Compliance with State Facility Active Treatment and Habilitation Clinical Care Expectations

The Civil Rights of Institutionalized Persons Act (CRIPA) established broad authority for the United States Department of Justice (DOJ) to investigate matters of infringement on the constitutional rights of patients cared for in state facilities. In the early 1990s, following initial investigations of the Northern Virginia Training Center and Eastern State Hospital, the DOJ called for plans of improvement to address findings related to patient care. Similarly, by the mid-1990s, Northern Virginia Mental Health Institute and Central State Hospital also were investigated, and each embarked upon the establishment of plans to address improvements in the care and treatment of patients in their respective facilities. General key requirements for DOJ approval of facility continuous improvement plans included:

- Increased staff-to-patient ratios;
- Enhanced staff training;
- Enhanced structure and provision for medical care;
- Increased individualized active treatment with patient involvement in treatment planning;
- Structured and coordinated planning for discharge and placement in the most integrated setting; and
- Focused efforts to protect patient and resident rights, safety, and well-being most specifically related to the use of seclusion and restraint.

By the fall of 2001, Northern Virginia Training Center, Eastern State Hospital, Northern Virginia Mental Health Institute, and Central State Hospital had successfully implemented their continuous improvement plans and their lawsuits were dismissed with prejudice. Western State Hospital continues to work with the Department and external consultants to prepare for a DOJ compliance audit. The Department's Office of Facility Operations/Quality Assurance continues to play a role in assuring that the facility plans of continuous improvement are successfully implemented.

In the summer of 2001, the Department's DOJ consultant was contracted to review the four mental retardation training centers that had not been reviewed by DOJ (Central Virginia Training Center, Southeastern Virginia Training Center, Southside Virginia Training Center, and Southwestern Virginia Training Center) with specific focus on: mental retardation diagnosis and resident level of functioning; psychiatric consultations, medications, and polypharmacy for residents with dual diagnoses; medical care and treatment; use of restraints and locked time out and each facility's adherence to the Department's administrative policies relating to risk management, abuse investigations, and quality improvement. As a result of these reviews, the

training centers were asked to prepare plans of improvement related to specific findings. In addition, the Department is seeking resources to increase staffing for each of these facilities to bring their staffing levels closer to compliance with DOJ expectations.

State Facility Clinical Guidelines Initiative

In FY 1999, the Department began an initiative to develop consistent and uniform clinical guidelines and operating procedures in areas such as state facility admissions and discharges, active treatment planning, medical assessment, medication management, medical emergency response systems, behavior management, emergency use of seclusion and restraints, abuse and neglect prevention, and competency-based staff training and development. These guidelines were based upon a systemwide review of state facility procedures and operations that affect the quality of care. Most of these procedures have been implemented by facilities. This initiative, however, has continued with the identification of additional areas for improvement, including suicide prevention, reporting and responding to unexplained injuries, peer review, and use of medical and protective restraints.

Uniform clinical guidelines and operating procedures are not intended to supercede clinical judgment but rather to promote and support clinical practice by ensuring that:

- the patient or resident receives the most effective services in a timely fashion;
- these services are delivered with caring and respect; and
- the interventions are provided in a manner that promotes the safety and well being of the individual receiving services.

The Department's uniform clinical guidelines and operating procedures continue to be based on and guided by the clinical skills and experience of facility professionals and expert consultants, the best currently available clinical evidence, the experiences of other public and private service agencies, and state and federal regulatory and certification requirements.

The Department plans to continue to redesign established uniform clinical guidelines and operating procedures to ensure that improvements in performance are sustained and that new improvement strategies and regulatory requirements are incorporated. A key aspect of this improvement effort involves monitoring the performance and effectiveness of new clinical guidelines and operating procedures to assess whether:

- the new processes produce the desired result;
- the processes require redesign; or
- there are opportunities to further improve the new guidelines and procedures.

Performance data, reflecting a wide range of clinical and operational activities, will be collected through a Quality Management Data System and used to identify service delivery trends and determine the need for new clinical guidelines and operating procedures. Ongoing evaluation of the effectiveness of uniform operating procedures and clinical processes will occur as a cooperative effort between the Department's Central Office and state facility quality managers, health information managers, training directors, and other facility personnel responsible for collecting or tracking clinical and regulatory data.

Phase I collection of performance evaluation measures for the uniform clinical guidelines and operating procedures will begin this fiscal year and will focus on:

- Compliance with documentation requirements as they relate to treatment planning and billing practices for treatment planning and related services;
- Compliance with mandatory orientation and annual training requirements;
- The effectiveness of the current preadmission process for medical screening; and
- The appropriateness, utilization, risk, and outcome of emergency seclusion and restraint procedures.

The Department's Office of Quality Management will work with state facility quality managers and the Office of Risk and Liability Affairs to establish final reporting and follow-up procedures for this quality assurance data.

Phase II implementation of the ongoing evaluation process will begin in FY 2003. Phase II performance evaluation measures will address the:

- appropriateness, utilization, and outcome of behavioral treatment techniques;

  quality and timeliness of emergency medical treatment response systems; and
- evaluation of medication prescribing practices and dosing strategies and the supporting documentation requirements.

Implementation of Evidence-Based Clinical Practices in State Facilities and CSBs

Evidence-based practice refers to the integration of the expertise and judgment of individual practitioners with the clinically relevant research into the effectiveness, efficiency, and safety of medical, psychiatric, rehabilitative, and behavioral treatments. In evidence-based practice, the current research evidence supplements and continuously updates the clinical expertise of practitioners to prevent their knowledge base from becoming outdated. This combination of practitioner experience and skill and the most efficacious treatments, coupled with individual choice, has the potential to significantly improve the quality of care for individuals receiving services. While evidence-based practice is not a new concept, advances in communication technology and the dissemination and transfer of information now give practitioners ready access to the best external evidence with which to address clinical questions in the course of their daily practice. This ready access to clinical information is extending the concept of a community standard of practice to a global standard of practice.

The first step in implementing evidence-based clinical practice is to educate practitioners on the benefits of such practice and provide them with the technical knowledge and skills that are needed for effective implementation. Any training must also dispel fears that evidence-based practice is "cook-book" treatment or habilitation that precludes clinical judgment and that it is a cost-cutting measure. While most of the literature describing evidence-based clinical practice focuses on medical practice, there are clearly applications for other disciplines, and this must be reflected in the audiences selected for training.

Evidence-based practice requires not only the effective and thoughtful utilization of research but it demands that such research be available. While external research provides a basis for evidence-based practice, this evidence is most effective when it is supplemented with data on specific populations and settings. Follow-up studies of patients within the services system may, for example, provide additional clinical information to support and supplement external findings.

The Department and CSBs have recognized the importance of working together to develop and disseminate evidence-based service models and uniform clinical practices that will promote substantial equivalence in services across the state. Adoption of uniform clinical practices by the CSBs would help ensure the provision of equivalent services throughout the state and permit a clearer identification of service system gaps, where they exist. While still allowing for local variation and innovation, a core set of evidence-based clinical practices for community services across the state also would help ensure informed consumer choices and ease of movement from one service area to another.

Under the auspices of the FY2001 community services performance contract, CSBs have been participating with the Department in a System Leadership Council to, in part: "identify, develop, propose, and monitor the implementation of new service modalities, systemic innovations, and other approaches for improving the accessibility, responsiveness, and cost effectiveness of the publicly funded mental health, mental retardation, and substance abuse services system." Workgroups of the Virginia Association of Community Services Boards (VACSB) Mental Health Council, with participation by Department staff, subsequently initiated a process of defining models for the essential array of mental health services. These models will include a description of the service, the intended target population, eligibility and exclusionary criteria, admission and discharge criteria, provider qualifications, caseload sizes, and service implementation standards. The first service models drafted include psychiatric inpatient care, emergency services, psychosocial rehabilitation, and PACT. Additional service models to be defined include outpatient, day treatment, residential, and case management.

In the area of substance abuse services, the population of persons with alcohol or drug use disorders is becoming increasingly diverse. Individuals are more likely to be polydrug users; be younger than their counterparts in previous years; represent a greater gender and ethnic mix; have more serious problems, such as co-morbid substance abuse and mental health disorders; and have a history of being psychologically and socially impoverished. When these persons present to the publicly-funded system of care for substance abuse treatment services, staff and treatment options must also become more diverse.

Limited public dollars can no longer support inefficient care provided in programs with one level of care and one treatment protocol for all consumers, regardless of the presumed or assessed clinical heterogeneity of the consumer population. There is an urgent need to find more efficient ways to provide care, to protect the quality of and access to addiction treatment, and to begin to integrate research findings into everyday practice and programs.

In addition to diagnosis, the severity of the addiction must determine the treatment modalities to be provided, with attention to matching consumers to appropriate levels of care and movement along a seamless continuum. Expert task forces and advisory committees have developed a number of nationally recognized substance abuse "Patient Placement Criteria" models. The criteria most widely used and adopted are American Society of Addiction Medicine (ASAM) patient placement criteria (PPC). The purpose of the ASAM-PPC, a consensus document, is to enhance the use of multidimensional assessments in making objective patient placement criteria decisions for various levels of care. Six assessment dimensions are evaluated in making placement decisions:

Dimension 1: Acute Intoxication and/or Withdrawal Potential
Dimension 2: Biomedical Conditions and Complications

Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications
Dimension 4: Readiness to Change
Dimension 5: Relapse, Continued Use or Continued Problem Potential
Dimension 6: Recovery/Living Environment

The ASAM-PPC-2R (2nd Edition-Revised, 2001) describes treatment as a continuum marked by five basic levels of care:

Level 0.5: Early Intervention
Level I: Outpatient Treatment
Level II: Intensive Outpatient/Partial Hospitalization Treatment
Level III: Residential/Inpatient Treatment
Level IV: Medically Managed Intensive Inpatient Treatment.

In the area of substance abuse prevention services, considerable attention has been given to identifying effective prevention programs. These programs have been thoroughly evaluated, published in peer review journals, and replicated and evaluated with different cultural and ethnic populations. They have been recognized by state and federal mental health, substance abuse, education, and juvenile justice systems as science-based programs or models. The Department is promoting increased use of these identified prevention programs by CSBs and has focused its training and technical assistance on these programs. Grants for purchase of science-based prevention program curriculum and training were distributed to CSBs in FY 2002. To assist the community-based prevention planning process, the Prevention and Promotion Advisory Council is completing the *Virginia DMHMRSAS Prevention Planning Guide: Phase III*. This guide will focus on current prevention science and science-based prevention programs for families. The guide follows two previous planning guides, all of which provided prevention practitioners with information on selecting and using evidence-based prevention programs for specific populations.

Medication Management

The Department's Medication Committee was reconstituted in FY 2001 to include representatives from a wide range of stakeholders in the public service system, including state facilities, community providers, and advocacy representatives. The Committee's charge is to improve the quality of care through assessment of the cost, utilization, and benefits of various pharmaceuticals in the publicly-financed services system. The Medication Committee, which initially met on a quarterly basis, now meets bi-monthly to consider a range of issues that include the rising cost of medications, the utilization of atypical medications, and Department's Aftercare Pharmacy services. Committee functions include:

- Reviewing candidate medications for inclusion in the state pharmacy;
- Reviewing the appropriateness, effectiveness, and safety of medication usage;
- Evaluating off-label use of certain medications, that is, medications that have not received FDA approval for a particular use, such as antidepressants used for the relief of anxiety;
- Studying innovative practices, including consultation and comparisons with other public mental health systems;
- Disseminating clinical guidelines and other best practices to practitioners in state facility and community settings;
- Serving as a forum for the exchange of ideas among physicians, pharmacists, psycho-

pharmacologists, and other clinical and administrative staff in state facility and CSB programs; and

- Reviewing the value of existing and new state facility structures and processes designed to evaluate medication usage, such as clinical pertinence reviews of polypharmacy and the adequacy of clinical trials.

One issue being considered by Medication Committee is the relationship between the Department's Aftercare Pharmacy, state facilities, and CSBs. During FY 2001, the Medication Committee conducted a study of CSB satisfaction with services provided by the Aftercare Pharmacy. Consumers discharged from facilities may and frequently do receive their pharmaceuticals from sources other than the Aftercare Pharmacy, such as private pharmacies and through mail order. This raised the question of the need to continue to operate an Aftercare Pharmacy when such services are available elsewhere. The study considered:

- the need for Aftercare Pharmacy services,
- the actual utilization of these services,
- the technical assistance needs of CSB and how well they were met by the Aftercare Pharmacy,
- patient access to pharmaceuticals through the Aftercare Pharmacy, and
- consumer satisfaction with Aftercare Pharmacy services.

This study showed an overwhelming support for the continuation of Aftercare Pharmacy services as a component of the overall delivery of pharmaceuticals in community programs.

The Medication Committee also has considered the role of pharmaceuticals in patient discharge readiness, community placement options, and readmission rates. State facility physicians have more options in their prescribing practices than CSB physicians because of the intensity of services provide in inpatient settings. State facility patients and residents are monitored by direct care staff 24 hours a day for drug interactions, side effects, and other unanticipated effects of medication. Inpatient treatment also allows facility physicians to conduct physical examinations and lab studies on patients as frequently as necessary to evaluate the effects of a medication or combination of medications. When an individual is discharged to a community setting, such intensive monitoring is rarely available and the community physician may, for safety reasons, find it advisable or necessary to change an individual's medication to one that requires less intensive monitoring, but that may be less effective.

The Medication Committee is developing preliminary plans to assess the effect of inpatient dosing strategies and prescribing practices on the choice of community placement, discharge decisions, and readmission rates and to develop strategies for improving continuity of care. Also planned is the development of strategies to promote fiscally responsible prescribing practices among community and state facility physicians. This will be accomplished by disseminating best-practice information and medication algorithms that physicians may use to make clinically sound and fiscally responsible judgments about the choice of a medication.

Quality Improvement Activities

Quality improvement is an ongoing process of identifying, measuring, assessing, and improving consumer care and providing a safe and secure environment. Department activities to

implement a systematic, organization-wide approach to quality improvement follow.

Performance and Outcomes Measurement System

Virginia's Performance and Outcomes Measurement System (POMS) assesses provider and system performance on several dimensions, including service access, quality and appropriateness of care, consumer outcomes, critical incidents, and consumer and family member satisfaction with services and supports provided to consumers in priority populations. The Department's goal is for POMS to provide mutually-useful data that is integrated into the culture of service delivery and that serves as the foundation for quality improvement activities. There is no intention to base the allocation of state-controlled funds on the POMS.

POMS provides a mechanism for the Department to evaluate services it funds as required by State Board policy (Policy 4021(CSB) 86-18). In addition, the federal government is beginning the process of requiring implementation of a national set of performance indicators as a condition of receiving federal block grant money for mental health and substance abuse services as part of the Performance Partnership Grants. The POMS provides the infrastructure to quickly and efficiently implement the national indicators. Finally, as of January 1999, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires all of the organizations it accredits to participate in an approved performance measurement system. The POMS is used to meet this requirement for the Department's state psychiatric hospitals.

The mental health (including child and adult populations in CSBs and state psychiatric facilities) and substance abuse POMS (adults served by CSBs) were implemented statewide, on October 1, 2000. The mental retardation POMS, which has been an active participant in the national Core Indicators Project, will be implemented on January 1, 2002, and the substance abuse prevention POMS is scheduled to begin statewide implementation on July 1, 2003.

POMS implementation is being phased in over several years, beginning with a limited number of adult and child/adolescent mental health and adult substance abuse phase one indicators in the following domains: access to services, quality and appropriateness of care, consumer outcomes, and consumer satisfaction. Examples of access indicators include:

- Access to substance abuse treatment within 48 hours for pregnant females, and
- Consumer perception of access (e.g., convenience of services, accessibility of staff).

Examples of quality or appropriateness indicators include:

- Follow-up services delivered within 7 days of state hospital discharge,
- Use of atypical medications (CSBs and state facilities),
- Seclusion and restraint (state facilities), and
- Consumer perception of the quality and appropriateness of services received.

Examples of consumer outcomes indicators include:

- Readmission within 30 days of hospital discharge,
- Community tenure,
- Employment,
- Level of functioning, and
- Consumer perception of outcomes.

Challenges encountered during the first year of implementation of the mental health adult, mental health child and adolescent, and substance abuse POMS included:

- Lack of information technology system capacity at CSBs,
- Integration of data collection with existing clinical protocols,
- Data management/tracking of consumers,
- Clinician concerns about consumer confidentiality, and
- Lack of national standards and benchmarks for data interpretation.

By August 2001, the POMS database included information on approximately 15,000 consumers. By program area these include approximately:

- 8,500 adult MH consumers
- 2,200 child MH consumers
- 3,500 adult SA consumers
- 1,000 dual diagnosis (MH/SA)

In collaboration with the CSBs and state hospitals, the Department has developed an internal process for using POMS data for quality improvement. The mechanism includes the establishment of Quality Teams to review POMS data on a routine basis, identify issues and areas for quality improvement, and make recommendations for future actions. The Department will also work with the CSBs and state facilities to enhance their ability to use POMS data for quality improvement.

The first reports of POMS data were distributed during the summer of 2001. The reporting schedule will include, at minimum, semi-annual and annual reports. Initially, these reports will focus on presenting state-level data; however, each CSB and state facility receives data on its individual performance so that they can use this information for local quality improvement efforts. Each CSB will continue to receive $40,000 in state general funds and an average of $10,000 in Mental Health Block Grant funds in FY 2001 to support its POMS implementation activities.

Quality Council

The Department's Quality Council was convened on November 8, 2000 to serve as the core structure for a comprehensive system-wide quality management program that encompasses the Central Office, 15 state facilities, and 40 CSBs. The Quality Council advises the Department on issues related to the process and outcome of treatment, satisfaction with care, the therapeutic environment, and consumer choice and skill-building opportunities. The Council's mission is to improve the quality of publicly-provided mental health, mental retardation, and substance abuse services by:

- promoting a culture of quality;
- identifying systemic issues influencing the effectiveness and stability of the organization=s processes and patient and family expectations and satisfaction with care; and
- making quality of care-based policy recommendations to improve the care and treatment of consumers.

The Quality Council establishes a focal point and provides continuity for the system's ongoing performance improvement functions. In this respect, the functions of Council are closely linked with the structure of the Department's Office of Health and Quality Care. The Quality

Council has a core membership representing key policy makers, clinical leaders, program administrators representing state facilities and CSBs, and consumers and family members.

The role of the Quality Council is being expanded beyond the traditional review functions to include individual Council member participation on quality teams established to address issues related to the quality of care. It is anticipated that this increased involvement in quality improvement activities will encourage members to assume a more active role in shaping Council direction and priorities. The Department also plans to expand Council membership to include private sector representatives and to increase the number of consumers and family members. With this expansion in mind, the format of Quality Council meetings has been revised to focus more on member's participation and their involvement in quality activities reported at scheduled meetings.

Peer Review Activities in State Facilities

The Department has developed a central medical peer review function to review the professional performance of practitioners in state facilities when significant issues in the quality of care are identified. Peer review is an important tool that allows practitioners to continuously evaluate and improve the quality of patient care through individual case reviews, the assessment of physician practice patterns, and the evaluation of systems and processes that support medical and clinical practice. Peer review enhances the effectiveness of state facility systems that are designed to improve performance.

Most recently the Department's Peer Review Committee convened a subcommittee of physicians with expertise in the treatment of persons with mental retardation. This subcommittee will review cases and address practice issues specifically related to the treatment and care of individuals with mental retardation. While most of the focus of the subcommittee will be on medical practice in training centers, they also will review practice as it relates to persons with mental retardation who are treated in state hospitals for psychiatric problems.

Peer review is a privilege afforded physicians under the *Health Care Quality Improvement Act of 1986* and by state laws governing peer review activities. It is critical that such a privilege be guided by a set of clear rules and requirements. To this end, the Department is preparing to develop policies and procedures to formalize the Department's central peer review process; to protect the confidentiality of patients and physicians; to ensure the appropriate use of peer review information; and to distinguish peer review from other review mechanisms.

Oversight of State Facility and Community Services

Oversight and Monitoring of State Facility Operations

In the summer of 2001, the Department established a separate Division of Facility Management within the Central Office to demonstrate the agency's commitment to and priority on promoting quality treatment and habilitation services in state mental health and mental retardation facilities and providing accountability for and oversight of state facility operations. This Division includes the Offices of Quality Improvement, Facility Investigations, and Forensic Services. Each of these offices plays a distinctive role in facility oversight and monitoring.

The Office of Quality Improvement works with the Office of the Attorney General (OAG) in providing oversight of the DOJ plans for continuous improvement and addresses implementation concerns. This involves reviewing specific quality of care issues within a state facility, including discharge practices, census issues, staffing, and program implementation concerns. Additionally,

the Office of Quality Improvement plays a broad role in addressing and monitoring facility-specific plans of improvement based on a variety of findings by external consultants, the Department's Internal Audit Office, and the Office of the Inspector General (OIG).

Created by legislation in 1999, the Office of the Inspector General's primary mission is to challenge Virginia's public mental health, mental retardation, and substance abuse services system to provide quality services that are consistent with contemporary clinical guidelines and financial management strategies. The OIG acts upon its mission through on-site inspections of the ten mental health facilities and five mental retardation training centers. These inspections may result in recommendations to the Department and the individual state facilities to correct identified problems, abuses, and deficiencies. The Inspector General is also responsible for keeping the Governor and the General Assembly fully informed of significant concerns, recommendations for corrective actions and progress made in the implementing these actions.

The OIG has three standardized inspection formats, one of which acts as the basis for each site visit. These formats follow.

- *Primary Inspections* - These are routine, unannounced comprehensive visits typically lasting several days. Their purpose is to evaluate all components of the quality of care delivered by the state facility and to make recommendations regarding performance improvement.
- *Secondary Inspections* - These are performed secondary to the identification of a potentially serious problem that may either represent a pattern of substandard care or may have a direct, immediate effect on patient health, safety, or welfare. Their purpose is to evaluate any potential problems and to make recommendations for performance improvement. These inspections may be announced or unannounced.
- *Snapshot Inspections* - These are brief inspections that are always unannounced and occur after regular work hours and on weekends. Their purpose is to review patient activities, staff coverage, and general building conditions. These inspections may serve as a means to follow-up on issues of particular concern at a particular facility.

During primary inspections, there are eight categories that are generally reviewed relative to quality of care. These are: treatment of patients with dignity and respect, use of seclusion and restraint, active treatment planning, access to acute medical care, the treatment and residential milieu, relationship of the facility with academic institutions, special facility issues, and risk management and quality assurance initiatives.

In the Inspector General's *2000 Annual Report*, there were several systemic findings of merit related to state facility quality care. These included the considerable decrease in the use of seclusion and restraint in state facilities, as compared to the recent past, and the increase in therapeutic activities and programs available to state facility patients and residents. The Inspector General also recognized that those staff observed during inspections appeared to be dedicated and professional and she called upon the Department to initiate opportunities for staff recognition. Though few, the Inspector General also noted systemic findings of concern related to staffing, aggression management, and an aging of the state facility capital infrastructure.

A primary responsibility of the Department's Office of Quality Improvement is to identify systemic areas where additional policy guidance is required. This Office serves as the Department's liaison to the OIG relative to investigations findings. Office staff and individual state facilities collaborate in responding to concerns raised by the Inspector General. The Office

works with each state facility to develop appropriate time frames and outcome measures for inclusion in their plans of correction. Implementation of these plans is then internally monitored. Between June 1999 and August 2001, the OIG conducted 47 inspections.

In 1999, the Department provided new and more specific guidance to state facilities on reporting and investigating facility allegations of abuse and neglect. Concurrently, the Department implemented centralized reporting of these incidents in state facilities to an Investigations Manager located in the Central Office. The Investigations Manager provides increased oversight of facility investigations, maintains data on case outcomes, and assures enhanced and standardized training of investigators. By late 2001, the system of investigating allegations of abuse and neglect in state facilities should be fully centralized with no investigator serving multiple roles within a facility. Instead, a cadre of investigators will be supervised by the Investigations Manager.

Oversight of Potential Risks and Liabilities in State Facilities

Efforts continue to enhance the implementation of standardized staffing levels, mixes, and credentials established by the Department through its State Facility Uniform Clinical Guidelines Initiative. The initial Risk Management departmental instruction (DI) established:

- requirements for the structure of distinct risk management programs at all 15 facilities under the oversight of the Central Office risk management director;
- minimum qualification criteria for facility risk managers;
- uniform risk identification strategies/ critical incident reporting, and
- an annual assessment of the program.

The departmental instruction outlined procedures for specific and systemwide risk management performance; monitoring risk and liability patterns and trends, including loss summary analyses; and notification to the Office of the Attorney General of actual or potential litigation.

In FY 2001, the Department's Office of Risk Management was renamed the Office of Risk and Liability Affairs to reflect the increasing need to assist management and the workforce in becoming proactive in addressing risks and liabilities encapsulated within ongoing programs and daily operations. Management of the Department's risks and liabilities has not only significantly increased, but has taken on new dimensions. In the past ten years, the Department has been exposed to liabilities stemming from the Department of Justice (DOJ) investigations and litigation against five state facilities for alleged violations pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). Also, pursuant to §51.5-37.1 of the *Code of Virginia,* the Department is now required to report all deaths and critical incidents to the Department for Rights of Virginians with Disabilities (DRVD) within 48 hours of occurrence or discovery, as well as follow-up reports of then known facts. A DRVD Incident Tracking System database has been established in Central Office to assure implementation, monitoring, and documentation of compliance.

The upcoming 2001 revisions to the Risk Management departmental instruction will provide for facility risk managers to assign clinical severity and risk assessment index codes to all incidents (approximately 3,000 per month) and to conduct baseline analyses and reviews on all unexplained injuries, as well as incidents with high severity and risk assessment levels. Quarterly report cards and full assessment data profiles will now be prepared for submission to the Commissioner, DRVD, Inspector General, and other appropriate offices within the Department.

These enhancements are intended to more effectively implement systemic identification and risk reduction strategies, and to ultimately improve client and community safety.

Oversight and Monitoring of CSB Performance Requirements

The FY 2001 and 2002 community services performance contracts continued many of the accountability enhancements instituted with the FY 2000 contract. Most notably, these included identifying three distinct types of state-controlled funding in the contract: ongoing services, special projects, and purchases of individualized services. Ongoing services are the continuation of traditional, grant-funded services, and they represent the major portion of CSB financial resources and services. However, the other two types of funding reflect a new approach to distributing state-controlled resources (state general funds and mental health and substance abuse federal block grants) in a more focused and accountable manner.

A. Special projects funding supports:

- mental health programs of assertive community treatment (PACT) teams at 12 CSBs,
- mental health assisted living facility (ALF) pilot projects at more than eight CSBs,
- mental health community residential services projects at all CSBs for individuals with serious mental illnesses,
- six regional substance abuse state facility diversion projects that cover all of the state except northern Virginia,
- community-based treatment services projects for women with alcohol and other drug addiction or abuse, and
- substance abuse jail services projects.

Information about these projects is projected separately in performance contracts and displayed separately in associated reports. In addition, the Department's Office of Mental Health Services maintains a separate automated monthly reporting system to track the implementation and operation of each PACT team. This system contains more detailed information about those teams than is contained in the performance contract and reports. The Office of Mental Health Services also maintains a separate reporting system for PATH projects, which fund services for individuals who are homeless.

B. Purchases of individualized services (POIS) funding supports:

- mental health discharge assistance project (DAP) placements based on individualized services plans for more than 300 former patients from state mental health facilities,
- individualized mental health services plans for children and adolescents with serious emotional disturbance who are non-CSA mandated at all 40 CSBs,
- individualized plans of care for consumers who are enrolled in the Medicaid mental retardation home and community-based waiver, and
- individualized plans of care for consumers who are not eligible for the Medicaid mental retardation home and community-based waiver.

Information about these purchases of individualized services is projected separately in performance contracts and displayed separately in associated reports. In addition, the Offices of Mental Health Services (DAP), Health and Quality Care (mental health child and

adolescent POIS), and Mental Retardation Services (mental retardation non-Waiver POIS) maintain separate automated monthly reporting systems to track the implementation and operations of these initiatives. These systems contain more detailed information about these POIS activities on an individual consumer basis. Individualized services plans or plans of care funded through these initiatives are preauthorized by Department staff and are subject to utilization review by the Department. The separate Discharge Assistance Project agreements that previously existed between the Department and individual CSBs have been incorporated into the community services performance contracts in FY 2002. Thus, on a limited basis, the Department has implemented some of aspects of the managed system of care proposal contained in the 2000 - 2006 Comprehensive State Plan.

Routine monitoring of CSB accomplishment of performance contract service objectives (e.g., numbers of consumers served, types and amounts of services provided) contained in Exhibit A of the contract continues, using the second, third, and fourth quarter automated reports submitted by each CSB. Additionally, other monitoring activities related to performance contract requirements are carried out by the following Department offices.

- The Office of Financial Assistance and Review conducts periodic financial management reviews of all CSBs to assess compliance with the Financial Management Standards for Community Services Manual. The office also reviews annual CSB and CSB contract agency CPA audits.
- The Offices of Financial Assistance and Review and Internal Audit conduct joint audits of selected CSBs on a periodic basis. These two offices also may conduct special ad hoc reviews of particular CSBs in response to requests from CSBs, complaints about CSBs, or information provided to the Department. These reviews may involve other offices in the Department, such as Community Contracting and Human Resource Development and Management.
- The Office of Reimbursement conducts periodic reimbursement reviews of all CSBs to determine compliance with the Community Services Reimbursement Policies and Procedures Manual.
- The Office of Administrative Services conducts periodic procurement reviews of all CSBs to evaluate compliance with the Community Services Procurement Manual.
- The Office of Human Rights reviews each CSB's local human rights plan, monitors compliance with the human rights regulations, and intervenes on an ad hoc basis to address allegations of human rights violations.
- The Office of Licensing conducts and makes annual unannounced visits to assess compliance of each service provided by each CSB with the Licensing Regulations and investigates complaints brought to the attention of the Office.

One of the most extensive monitoring efforts instituted as a result of the FY 2001 performance contract and the increased emphasis on predischarge planning involved the development and implementation of a separate quarterly automated system to track the status of patients in state mental health facilities who have been determined to be ready for discharge and residents in state mental retardation facilities who have chosen to be discharged. State facilities report this information, based on their records, on a monthly basis to the Department and the CSBs that they serve. CSBs report similar information, based on their records, to the Department

on a quarterly basis. The purpose of this system is to monitor the movement of such individuals into their communities. This system also enables the Department to gather information as part of its response to the Olmstead decision.

As part of its ongoing efforts to streamline data and reporting requirements, lessen the administrative workload of CSBs, and decrease the burden on direct care staff, the Department reduced data and reporting requirements associated with the community services performance contract and reports significantly for FY 2001 and 2002. For example, the number of pages in Exhibit A of the contract decreased from 62 in the FY 2001 contract to only 30 pages in the FY 2002 contract, if a CSB uses all of the forms. There was a comparable reduction in the reports associated with the contract for FY 2001. This streamlining was possible, in part, because of the information gathered by ancillary systems, such as the PACT and DAP software, and by a detailed and thorough review of the Department's actual information needs.

While the Department's oversight and monitoring activities have increased appreciably, the major accountability tool governing relationships between the Department and the CSBs contains few usable or useful enforcement or sanction mechanisms. Currently, the contract contains minor sanctions for non-performance, associated with the submission of accurate and timely reports, and withdrawal of funds or termination of the contract for unremediated patterns of non-compliance with the terms of the contract. In the context of effective monitoring of contract performance, it may be helpful to have alternatives that are less severe than termination, but more meaningful than small one-time reductions of state funds for late reports.

Finally, another major effort to monitor CSB performance, the Performance and Outcomes Measurement System is being implemented in a phased approach. Once POMS is fully operational, it will provide a rich source of information about the performance of individual CSBs and many opportunities for significant quality improvement activities.

Monitoring Human Rights Protections in State Facilities and Community Programs

The Department's human rights program is designed to provide comprehensive human rights protections and a complaint resolution process for individuals receiving services in the 15 state mental health and mental retardation facilities, programs operated by or under contract to the 40 CSBs, and over 450 licensed private mental health, mental retardation and substance abuse programs throughout Virginia. There are 25 advocates who are physically housed at state facilities. Nineteen advocates provide advocacy services to individuals receiving services in state facilities. Six regional advocates provide services to individuals receiving services in the CSBs and licensed community programs in their respective areas. These advocates are responsible for large caseloads, large numbers of CSBs and private programs, and many Local Human Rights Committees (LHRCs). The size of the caseloads and geographic distance do not enable these advocates to have a significant presence in community programs.

The Department's Human Rights program monitors all state facilities and licensed providers for compliance with the human rights regulations. This monitoring function may occur during an abuse or neglect investigation, while resolving other human right complaints, or during an unannounced visit to the unit, program or service location. The Department's Office of Licensing shares responsibility for monitoring compliance with the human rights regulations and frequently staff from both Offices conduct joint visits or investigations. In accordance with §37.1-84-1 and §37.1-179 of the *Code of Virginia*, providers must be in compliance with the human rights

regulations to obtain or retain a license from the Department.

The human rights oversight function is carried out by the Department's Office of Human Rights staff and the Local Human Rights Committees (LHRC). Each provider is required to establish or affiliate with an LHRC and report human rights complaints to the Department advocate. The LHRC and advocate are available for the resolution of human rights complaints through the complaint and hearing process as detailed in the human rights regulations.

The Office of Human Rights also conducts training on the human rights regulations for staff and consumers at state facilities and community programs. These training opportunities are part of the monitoring and oversight function of the Office of Human Rights.

Strengthened Licensing Requirements and Oversight

The Department drafted proposed new licensing regulations (12 VAC 35-105 *Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services*) during the spring of 2001. These proposed regulations would replace the current licensing regulations for regulating and monitoring the compliance of all providers of care and treatment services provided to individuals with mental illness, mental retardation, or substance abuse or dependence. The regulations have three overarching goals:

- To increase consumer protection and safety;
- To increase provider accountability; and
- To maintain, to the greatest extent possible, the flexibility found in the current licensing regulations.

The Department's Office of Licensing convened external and internal workgroups to assist in the development of its proposed new regulations. The external workgroup included organizations representing consumers, family members, public and private providers, and others. The internal workgroup included Department offices that have collaborative relationships with licensing. Suggestions from both workgroups were incorporated into the draft regulations wherever possible.

One notable feature of the proposed regulations is the increased collaboration between licensing and human rights. Changes to §37.1-84.1 and §37.1-182.3 of the *Code of Virginia* require substantial compliance with human rights regulations for the purpose of issuing a license. These changes further call for the ongoing monitoring of compliance with human rights regulations as part of routine licensing inspections. Changes to §37.1-185.1 of the *Code* call for the possible imposition of sanctions against providers for violations of licensing and human rights regulations. The proposed regulations reflect these statutory changes.

The proposed licensing regulations are currently proceeding through the regulatory development process. The State Board has approved the proposed regulations for public comment and the Department has submitted these proposed regulations for Executive review. The proposed regulations received the required Executive approvals on October 1, 2001 and were published in the Virginia Register on November 5, 2001. The next steps in the regulatory process include:

- Public hearings and 60-day public comment period through January 5, 2002;
- Analysis of comments received and incorporation by the State Board of any revisions;
- Submission of final regulation for Executive review by May 5, 2001;
- Thirty day publication of the proposed final regulations in the Virginia Register; and

- Final promulgation.

Goals, Objectives, and Strategies

Goal: Achieve professionally-recognized clinical best practices in state mental health and mental retardation facilities.

Objectives:

1. Bring all state mental health and mental retardation facilities up to the active treatment and staffing levels provided in the Department's settlement agreements with the U.S. Department of Justice (DOJ) under the Civil Rights of Institutionalized Persons Act (CRIPA).

Strategies:

a. Continue to implement plans of improvement at Western State Hospital.

b. Maintain compliance with provisions of the former DOJ settlement agreements at the Northern Virginia Training Center, Eastern State Hospital, Northern Virginia Mental Health Institute, and Central State Hospital.

c. Work with Central Virginia Training Center, Southeastern Virginia Training Center, Southside Virginia Training Center, and Southwestern Virginia Training Center to improve service quality and increase staffing to bring them closer to compliance with DOJ expectations at the Northern Virginia Training Center.

d. Support the efforts of the Inspector General to monitor the progress of state facilities in improving quality of care.

Goal: Establish a mechanism for the ongoing evaluation of clinical performance in state mental health facilities and training centers.

Objectives:

1. Implement Phase I variables for the evaluation of uniform state facility clinical guidelines and operating procedures in FY 2002.

Strategies:

a. Identify performance measures for the initial variable set that will become a regular part of state facility data collection efforts.

b. Develop Department-wide definitions for Phase I variables.

c. Develop a data transfer mechanism for downloading data from state facilities to the Department's Quality Management and Training Office.

d. Develop reporting formats and methods for analyzing this data.

e. Assess data definitions, data reliability, and evaluation methods and make revisions as needed.

2. Develop and implement Phase II variables for the evaluation of uniform state facility clinical guidelines and operating procedures in FY 2003.

Strategies:

a. Work with state facility clinical leaders and quality managers to identify variables, reporting formats, and methods for analyzing the results of data for the evaluation of the

performance of uniform clinical procedures.

b. Implement data collection, analysis, and reporting on Phase II variables.

c. Assess data definitions, data reliability, and evaluation methods and make revisions as needed.

Goal: Implement evidence-based clinical practice in state facilities and CSBs.

Objectives:

1. Provide training in evidence-based clinical practice to CSBs, state facilities, and other treatment professionals.

Strategies:

a. Continue to review research findings in the literature and work with national experts to identify appropriate evidence-based clinical practices for potential replication across the mental health, mental retardation, and substance abuse services systems.

b. Host symposiums, forums, and other training sessions on specific evidence-based clinical practices in FY 2003.

c. Disseminate literature on specific best practices, including evidence-based medical and pharmacology practices, to CSB and state facility clinical practitioners.

d. Identify practitioners within Virginia's public and private services system who are using evidence-based practices and who would be willing to provide training and assistance to CSB and state facility clinical practitioners.

e. Develop training strategies and related activities to inform community practitioners about the benefits of evidence-based practice in FY 2003.

f. Establish mechanisms for the sharing of information about evidence-based practice between community psychiatrists and facility psychiatrists in both the public and private sectors in FY 2003.

g. Develop a training program to address the quality and risk implications of evidence-based practice for the individual practitioner, the organization, and the larger system.

h. Collaborate with national experts on research and program evaluations to study the effectiveness of implementing evidence-based practices for specific populations and in certain settings in Virginia's public sector.

Goal: Improve consumer outcomes and access to individualized substance abuse treatment that is more cost efficient and cost effective.

Objectives:

1. Improve the assessment, evaluation, and treatment skills of substance abuse clinicians related to substance abuse disorders.

Strategies:

a. Provide information about patient assessment and placement criteria and practice guidelines to CSB professional staff, state mental health facility psychosocial rehabilitation staff, and publicly-funded private treatment providers.

b. Facilitate the development of broad consensus for the implementation of patient placement criteria among significant stakeholders.

c. Promote an understanding of the distinctions between professional treatment and self-help groups, including 12-step programs, that provide social and spiritual aids to recovery but do not meet treatment criteria and should not be confused with or substituted for professional treatment.

d. Improve collaboration between the Department, CSBs, the Mid-Atlantic Addiction Technology Transfer Center (ATTC), and professional organizations.

e. Facilitate the development in FY 2003 of specific policies and procedures to enhance the linkage of services required by individuals with co-occurring mental health and substance-related disorders.

f. Cross-train professional staff, beginning in FY 2003, to serve individuals with both mental health and substance-related disorders and to address both types of disorders in the psycho-educational components of treatment.

g. Provide training about incorporating medication management into treatment planning and monitoring and promoting compliance with pharmacological therapies.

h. Utilize outcomes data to continuously improve the implementation of the criteria and guidelines.

Goal: Continuously improve the quality of medication services to consumers in the public services system through incremental changes and significant revisions to the system of care.

Objectives:

1. Continuously monitor products, services, and practices related to efficacious and safe medication usage in state facilities and CSBs through the Medication Committee.

Strategies:

a. Review and assess the appropriateness, effectiveness, and safety of medications.

b. Review issues related to the evaluation of medications and physician practices in state facility programs and develop recommendations for improvement.

c. Identify and address issues related to Aftercare Pharmacy services as they relate to access, utilization, and quality.

d. Promote clinically efficacious and safe medication practices by identifying and disseminating relevant research to physicians, pharmacologists, psycho-pharmacologists, and other practitioners in facility and community programs.

e. Promote responsible prescribing practices by distributing research and algorithms to assist physicians in making choices about medications.

2. Improve the continuity of medical care between state facility and community programs.

Strategies:

a. Conduct a study of the impact of facility physicians' prescribing practices and medication strategies on length of stay and readmissions in FY 2003.

b. Identify medication practices that may impact discharge, community placement, and readmissions in FY 2003.

b. Work with state facility medical directors to evaluate the clinical necessity of practices

c.

that impact discharge and identify practices that should be revised to improve patient care.

d. Identify organizational processes and requirements in state facility and community programs that maintain clinical practices that may impact the continuity of care in FY 2003.

e. Develop strategies in FY 2004 to modify clinical practices and organizational processes with the goal of improving medication practices that may impede discharge or place a patient at risk of re-hospitalization.

Goal: Continue to expand the role of quality improvement in the Department's oversight of clinical performance improvement.

Objectives:

1. Continue statewide implementation of Virginia's Performance and Outcomes Measurement System (POMS) activities.

Strategies:

a. Convene quality teams on a regular basis to analyze POMS data to identify issues and make recommendations for state-level quality improvement activities.

b. Develop and disseminate semi-annual and annual reports of state-level data.

c. Provide technical assistance to and support for CSB and state facility quality improvement activities that focus on POMS data.

d. Implement mental retardation POMS in FY 2002 and substance abuse prevention POMS in FY 2004.

2. Include Quality Council members in systemic quality improvement activities of the Department.

Strategies:

a. Establish procedures in FY 2002 to continuously identify and involve Quality Council members, as appropriate, in Departmental performance improvement activities.

b. Establish mechanisms in FY 2002 to give Quality Council members a greater role in shaping the direction of the Council.

c. Establish written by-laws in FY 2003 that define the membership, structure, and functions of the Quality Council.

d. Work with the Quality Council to expand its membership to include private sector participation in FY 2004.

3. Develop Departmental policies and procedures to guide the function of the Department=s Peer Review Committee.

Strategies:

a. Collect information in FY 2003 related to the function of central peer review committees established in other large mental health systems.

b. Prepare a paper in FY 2003 that distinguishes central peer review activities from other Departmental performance-related review activities.

d. Develop a Departmental Instruction in FY 2004 to establish requirements for the

Department's peer review function to include: composition of the committee, tenure on the committee, frequency and conduct of meetings, criteria for referral, reporting results, use of outside experts and protection of information.

d. Require that all state facilities have clearly articulated procedures for conducting peer review as part of their medical staff by-laws in FY 2004.

e. Train all facility medical staff on the new requirements in FY 2004.

Goal: Enhance and expand appropriate monitoring and oversight of CSB performance, while streamlining data and reporting requirements wherever possible, to increase the quality, accessibility, and accountability of services; strengthen the effectiveness of CSB services; and improve the lives of individuals who need these services.

Objectives:

1. Implement processes to share applicable information among Department offices for more effective and efficient monitoring of CSB performance.

Strategies:

a. Develop and implement in FY 2003 a process for sharing information among affected offices in the Department's Central Office to enable more complete monitoring of CSB performance in fulfilling the terms of the performance contract.

b. Develop and implement in FY 2004 a standardized monitoring instrument, in conjunction with the first activity and with input from the CSBs, to assess each CSB's accomplishment of key provisions of the performance contract on an ongoing basis.

c. Share information from the standardized monitoring instrument with appropriate Department offices.

d. Implement separate, more detailed reporting requirements in FY 2002 for the six regional substance abuse state facility diversion projects; SAPT block grant set-aside special projects for HIV/TB, women's substance abuse, and prevention services; and other projects that require additional data for distinct requirements though separate memoranda of agreement between the CSBs and the Department.

e. Streamline existing data and reporting requirements whenever possible, while maintaining adequate accountability for funding and services.

2. Monitor CSB usage of state facility resources.

Strategies:

a. Update in 2003 the Department's methodology for assigning CSB bed targets for adult non-forensic utilization of state mental health facility beds.

b. Monitor and report CSB state mental health facility bed utilization related to their bed targets.

c. Develop in 2003, with CSB, state facility, and other stakeholder input, a mechanism to identify and measure the cost of state facility resources consumed by each CSB.

d. Implement this mechanism and generate reports for CSBs, state facilities, and the Department in FY 2004.

3. Examine the feasibility of intermediate sanctions in future performance contracts.

Strategies:

a. Investigate the feasibility and practicality of developing and implementing a range of intermediate sanctions in future performance contracts in FY 2003.

b. Involve the CSBs and other system stakeholders in these deliberations.

c. Develop, if the results of this effort indicate that such intermediate sanctions are feasible and practical, a proposal to institute such sanctions with the FY 2004 performance contract.

Goal: Enhance the Department's oversight of human rights protections and quality of care standards in state facilities and community programs.

Objectives:

1. Implement the new human rights regulation.

Strategies:

a. Develop and implement training in FY 2002 for services providers, members of the State Human Rights Committee and Local Human Rights Committees, provider organizations, and consumer and family organizations on the new human rights regulation.

b. Provide technical assistance to services providers on new or changed requirements.

c. Seek resources to increase the number of human rights advocates in order to respond to growing workload demands and new requirements for integration with licensing staff.

d. Collect data and prepare routine reports on human rights complaints and abuse and neglect investigations.

e. Make recommendations to the Commissioner on trends and systemic issues requiring policy or administrative interventions.

2. Strengthen the Department's licensing program.

Strategies:

a. Seek resources to increase the number of licensing specialists to respond to growing workload demands and new requirements for integration with human rights staff.

b. Promulgate new licensing regulations for mental health, mental retardation, and substance abuse services that incorporate new statutory requirements.

HUMAN RESOURCES MANAGEMENT AND DEVELOPMENT

There are several major human resource related factors that are expected to affect the quality, responsiveness, and effectiveness of services provided through Virginia's publicly-funded services system. These include:

- the aging and increasing cultural diversity of the current workforce,
- declining enrollments in key degree programs such as nursing,
- the shortage of health care professionals and direct care workers, and
- the increasing level of skills expected of the workforce in the future.

Nationally, nearly 83 million Americans now working were born in the two decades following the end of World War II. This generation of workers, commonly referred to as "baby

boomers," will be nearing the traditional age of retirement in the near future. The first individuals in this generation will turn 65 around 2010. While many professional and managerial individuals, such as social workers, psychologists, and managers, are likely to remain in the workforce longer than the generation of workers before them, state facilities and community programs will experience increasingly larger numbers of retirements among their workforces. On the other hand, direct care providers in state facilities and residential aides and personal care staff in community programs, who have spent 20 or 30 years in physically demanding jobs, may be ready to retire around 2005. These departures will have a profound impact on the services system.

A rapidly changing and more entrepreneurial economy has placed a premium on both adaptability and flexibility. Workers able to master technology and cope with change will have an advantage. Technology will increase the demand for highly skilled and well-educated workers. The economy's increasing emphasis on services will continue to create many new jobs that will be filled by workers who span the spectrum from highly skilled to moderately skilled workers, including many who might be candidates for recruitment by state facilities and community programs. Companies that cannot compete in the marketplace, even those that once had been monopolies, will not survive. As a result, workers will likely change jobs, employers, and even occupations more often than in the past. Workers in all occupations will need to prepare themselves mentally and professionally for this uncertainty.

The Bureau of Labor Statistics has projected changes for the number of workers in more than 500 occupations between 1994 and 2005. Demand for jobs in seven of the 25 fastest growing occupations are estimated to be in health care positions utilized within Virginia's publicly-funded services system. These include personal and home care aides, home health aides, physical therapists, residential counselors, human services workers, teachers of special education, and other health service workers. Many of these occupations require moderately skilled workers who must possess well-honed communication and reasoning capabilities. A college degree is a plus but not an absolute requirement. State facility nurses for example, range in qualifications from those with two-year certificates or associates degrees to bachelors and masters prepared nurses.

Demand for nursing care has already outstripped the supply and the services system is facing increasing competition for health care aides and other entry-level workers from retail chains that offer benefits and pay comparable salaries. The Department is experiencing increasing difficulty recruiting nursing and health care aides. The CSBs report increasing difficulty in recruiting and retaining staff who provide personal assistance and support. This shortage is expected to continue and grow worse as pressures on demand and supply increase.

- Demand pressures include general population growth and the aging and increased medical frailty of individuals receiving services. Greater proportions of individuals receiving state facility and community services have significant medical conditions and complex care needs.
- Supply pressures include the aging of the provider workforce and increased opportunities in other fields. In a *Briefing on the Condition of the Nursing Workforce: U.S. and Virginia* to the Joint Commission on Health Care earlier this year, Dr. P. J. Maddox cited data from the National Sample Survey of Registered Nurses conducted by the U.S. Bureau of Health Professions on educational trends influencing the nursing workforce: decreased enrollments and graduations, expanding career options, capacity, and aging faculty. According to Dr. Maddox, the national percentage of registered nurses who are under age 40 has decreased from 51.3 percent in 1980 to 31.7 percent in 2000. In 2000, only 9.1 percent of nurses were

under age 30. The average age of employed registered nurses was 43.3 years. The issue of an aging workforce is not limited to nurses. The average age of employees in state mental health and mental retardation facilities is now 45 years.

To retain its pool of workers, state facility and community providers must adapt at all levels to a situation in which workers in general, and particularly skilled and motivated workers, are likely to be in short supply. For example, good workers willing to commute to traditional nine-to-five jobs will be even harder to keep because there will be so many flextime and home-office options. This is all new, and it requires a very different approach to workforce issues. *Workforce 2020* suggests that: "Perceptive state and local governments will bend over backwards to make workers feel that they are getting value for their tax dollars, and that it is worthwhile to work." (*Workforce 2020*, page 130) Department employees have said they need to see that their suggestions and observations are given serious consideration within treatment team meetings, staff meetings and the like, and that they are generally treated with dignity and respect. They indicate that how their supervisors treat them and how they view their potential for growth are very important to them and their decisions to remain within the services system.

Because the overall size of the workforce is projected to grow slowly, the productivity of individual workers must rise. This will require technology improvements, better matching of workforce skills with consumer needs and acuity levels, and more workforce education on new treatment modalities and professionally accepted clinical practices. Workforce training also is an important key to employee satisfaction and professional growth. A variety of education and compensation incentives will be needed to enhance skill levels and retain workers in key health care occupations, including on-site formal education for nurses, health care aides, case managers, and other licensed providers; tuition reimbursement; and grants for off-site educational programs. The community college system has expressed an interest and willingness to assist in this educational effort. Further, the utilization within Virginia's publicly-funded services system of career ladder models that support advancement through the attainment and application of successively higher levels of competencies will be increasingly important.

In July 2001, the U.S. Department of Health and Human Services Office of Minority Health released national standards on Culturally and Linguistically Appropriate Services (CLAS) in health care. The CLAS standards are organized by three themes: Culturally Competent Care (standards 1-3), Language Access Services (standards 4-7), and Organizational Supports (standards 8-14). Within this framework, these standards are broken down into three levels of stringency: mandates (intended for all recipients of Federal funds), guidelines, and recommendations. There is a federal mandate to identify the non-English languages that are used by individuals who access health and social services. Services providers must identify the:

- language needs of each limited English proficient (LEP) client,
- points of contact in the organization where language assistance is likely to be needed, and
- availability of resources and ways to access them in order to provide timely language assistance.

A multi-agency response to identify and provide trained and competent interpreters and other language assistance services may be appropriate and a more efficacious use of resources to ensure staff training.

There are a number of human resources issues related to the implementation of Virginia's Early Intervention (Part C) program. Early intervention legislation was enacted by Congress in 1986 as an amendment to the Education of Handicapped Children's Act (1975) to ensure that all children with disabilities from birth through the age of three would receive appropriate early intervention services. This amendment formed Part H of the Act, which was re-authorized in 1991 and renamed the Individuals with Disabilities Education Act (IDEA). IDEA was reauthorized in 1998 and Part H became Part C of the Act. Federal regulations require persons working in early intervention to meet the highest standards for their profession or discipline. This means the highest entry-level academic degree needed for any State-approved or recognized certification, licensing, registration or other comparable requirements that apply to the profession or discipline. Early intervention services must be provided by qualified personnel including: audiologists, family therapists, nurses, nutritionists, occupational therapists, orientation and mobility specialists, physical therapists, pediatricians and other physicians, psychologists, social workers, special educators and speech-language pathologists.

Challenges abound within the field of early intervention to continue to address cultural, linguistic, ethnic, and socioeconomic service delivery issues, a well-trained work force, with the most current and up-to-date information on practices in early intervention, as well as caseload numbers and practices for service coordinators and other providers of early intervention entitled services.

In Virginia, by July 1, 2002, all personnel working as early intervention personnel must meet qualified personnel standards. However, there are early intervention personnel who do not meet highest requirements of their profession or discipline. For these individuals, a temporary category has been developed for Early Intervention Generalists as an emergency measure to allow persons to continue their employment until 2002 if they were employed in the state's early intervention system prior to September 1993.

Significant increases in the number of early intervention personnel are required, especially in the areas of pediatric occupational therapists, special instructors, physical therapists, and teachers for infants and toddlers who are hearing impaired. Virginia's Part C system has developed the Early Intervention Assistant (EIA) position to address personnel shortages; increase the diversity of persons working with infants and toddlers; and increase the consistency of knowledge, skills, and abilities of early intervention personnel employed across the state in assistant and paraprofessional positions. The EIA occupational category will increase opportunities for providers to employ family members of children with disabilities and other individuals with diverse backgrounds, including persons who are moving from welfare to work. Additionally, it will allow individuals currently practicing as Early Intervention Generalists to complete the EIA application process, and upon approval of their qualifications, to be fully recognized providers of early intervention services within the limits of the scope of responsibilities of an EIA.

Along with the Early Intervention Assistant occupational category, Virginia's Part C Office has partnered with the Virginia Department of Education to assure that early intervention personnel meet a recognized standard even when they might have a non-traditional educational background through technical professional licenses. Personnel employed in the Part C system who hold appropriate degrees or knowledge, skills, and abilities can be awarded the Collegiate Professional License in Early/Primary Education PreK-3, or Early Childhood Special Education, or the Technical Professional License in Work and Family Studies. Additionally, tuition

assistance has been available to early intervention personnel who are enrolled in a collegiate degree-granting program to achieve one of Virginia's recognized highest standards. A stipend of $400 per semester has been granted to approved applicants upon successful completion of the course and achievement of a specified grade.

Statewide and regional training has allowed easy accessibility to current knowledge and practice for an array of public and private providers within the early intervention system. Because training needs for early intervention staff vary across Virginia, the most recent training events have been held regionally to provide interagency training, including both public and private providers on:

- the implementation of the statewide IFSP and statewide procedural safeguards forms;
- natural environments requirements and implementation of such requirements in the service delivery system;
- models of using therapists as consultants, and using informal supports with children and families; and
- interagency training on financial and fiscal issues.

Additionally, training has been provided on an ongoing basis to physicians and nurses, addressing the medical community's role in identification and referral of young children to early intervention, as well as the medical provider's significant role in the evaluation and service delivery system for infants and toddlers. Interagency training with the Virginia Department of Health, the Virginia Department of Education, and the Part C Office has been provided, again regionally, on the implementation of Universal Newborn Hearing Screening, and on service delivery issues in meeting the needs of those infants who may be identified with a hearing loss.

Goals, Objectives, and Strategies

Goal: Promote the attainment of a high quality services system work force that is competent, motivated, and dedicated to providing services and supports that improve the lives of individuals receiving mental health, mental retardation, and substance abuse services.

Objectives:

1. ***Establish a methodology or methodologies for forecasting future staffing needs in community programs and state facilities based on population and education trends.***

   Strategies:

   a. Assess, in collaboration with state institutions of higher educations, CSBs, and state facility staff, potential approaches for forecasting future staff needs in specific service areas in FY 2003.

   b. Test forecasting methodologies that may have applicability for the publicly-funded mental health, mental retardation, and substance abuse services system in FY 2004.

   c. Work with state higher education institutions and community colleges to incorporate staffing needs projected through the forecasting methodology into their planning.

2. ***Develop and implement a systemic and integrated response for recruiting difficult-to-fill positions in state facilities and publicly-funded community programs.***

Strategies:

a. Complete a survey in FY 2003 of both the Department and CSBs to determine what vacancies are the most critical and most difficult-to-fill.

b. From the survey information, develop and maintain an updated list of advertisement sources, including newspapers, publications, web sites and related organizations and associations, that are most effective in attracting candidates who meet entry level requirements of critical and difficult-to-fill position vacancies.

c. Survey advertisements of critical and difficult-to-fill vacancies to determine whether requested qualifications potentially produce prospective applicants requirements that do not expand an applicant pool.

d. Make recommendations in FY 2003 to state facilities and CSBs regarding statements of knowledge, skills, abilities, and personal characteristics (KSAPs) that may be overstated or may lack or place questionable emphasis on specific years of experience necessary to assure satisfaction of Equal Opportunity Employer responsibilities.

e. Develop and maintain recruitment lists by occupational groups.

f. Provide training and information in FY 2003 to services system providers on creative and nontraditional strategies for recruiting qualified applicants from minority communities.

g. Identify state college and university programs and their student allocations that directly relate to mental health, mental retardation, and substance abuse service disciplines in FY 2003.

h. Work with the State Council on Higher Education and Virginia college and university programs to address any shortfalls and needs to expand program offerings to meet future human resource needs required by the services system.

i. Promote employment at the Department and CSBs through mass media resources, including promotional materials that can also be accessed on agency web sites.

3. Develop and implement a systemic and integrated response for identifying and addressing reasons why services system employees are leaving the workforce.

Strategies:

a. Track the turnover rates of key positions in state mental health and mental retardation facilities to identify trends that may require further analysis and intervention by state facility and state human resources personnel.

b. Survey the use and results of exit interviews in two pilot state facilities and two pilot CSBs (one urban and one rural) in FY 2003 to determine major reasons employees are leaving employment.

c. Assess the pilot survey experience and results to determine the feasibility and benefits of expanding exit interview surveys to other state facilities and CSBs in FY 2003.

d. Interview a sample of ex-employees as to why they left the Department or the CSB and develop a plan to address these particular reasons in FY 2003.

e. Assess the extent to which Department and selected CSB compensation plans support retention and report conclusions in FY 2003.

f. Review Department and selected CSB current benefit programs in FY 2003 and compare these programs with comparable private and other public sector employers.

g. Complete on-site job audits of critical positions in FY 2003 to determine if the requirements of the positions are being performed and determine their impact on current employees in terms of their job satisfaction.

h. Encourage state facilities and CSBs to regularly assess, through employee focus groups and other opportunities for input, working conditions that may adversely affect retention and take steps toward resolution of these conditions.

i. Survey Department central office and state facility managers and supervisors in FY 2003 to determine their need for in-service training that can positively impact on their working relationships with subordinates.

j. Develop in FY 2004 and implement a positive public or community relations program emphasizing the positive stories and aspects related to services system employees and the quality of care they provide to their patients and clients.

4. Avoid over- and underutilizing staff resources by matching employee skills with clinical service needs and appropriate professional practice guidelines.

Strategies:

a. Implement a clearinghouse-type effort to disseminate information about state-of-the-art, research-based, best practice models, and standards in FY 2004.

b. Include the use of web-based technology and establish linkages to a library of clinical guidelines and standards, ensuring wide access by providers.

c. Develop the capacity to provide technical assistance in FY 2004 in establishing and implementing standardized acuity and work rating systems in state facilities and community providers for high volume job classifications.

d. Conduct a work analysis in FY 2004 on a sample of state facilities to determine the match between the facility's mission, the scope of practice, the service delivery model in place, and clinical job categories. Encourage CSBs to conduct similar analyses.

5. Identify knowledge, skills and abilities that underlie competent professional practice.

Strategies:

a. Establish prerequisites for competencies in each discipline working in the behavioral health field in FY 2004.

b. Promote professional development through clinical supervision, and training and encourage participation in self-improvement activities including membership in professional organizations, certification, and credentialing.

c. Encourage exceptional practice through administration of the State's compensation plan.

d. Explore the feasibility of establishing a Center for Nursing Evaluation and Research with one or more university centers for the purposes of conducting studies in behavioral health nursing, publishing these findings, and promote the participation of the professional community in the care of individuals receiving services in FY 2005.

6. Take affirmative steps to promote workplace environments in which the cultural context of each employee and individual receiving services is valued and supported.

Strategies:

a. Develop, in collaboration with public and private services providers, an instrument to

determine the extent to which Culturally and Linguistically Appropriate Services (CLAS) standards are being implemented.

b. Administer the instrument and incorporate the findings of this assessment into an implementation plan in FY 2003.

c. Work with state facilities and CSBs to identify all languages necessary according to census data and geographical location and identify what positions are required to be versed in more than one language.

d. Explore options for providing financial incentives to employees who are able to perform job tasks utilizing more than one language.

e. Include required language competencies in vacant position advertisements, emphasizing the provision of services to a diverse population of individuals receiving services and the cultural diversity of the workplace.

f. Emphasize cultural diversity as part of state facility and CSB initial employee orientation.

g. Develop the capacity across the services system to support the expansion of clinical, direct care, and administrative positions that are proficient in communicating with individuals who are deaf or hard-of-hearing, or who have other sensory impairments.

h. Encourage services providers to attain proficiency in communicating with individuals who are deaf or hard-of-hearing, or who have other sensory impairments either at the time of initial employment or within a specified period of time through specialized training and to provide additional compensation to employees with demonstrated proficiency.

7. Create opportunities for workforce training, professional growth, and staff development.

Strategies:

a. Develop mechanisms to identify the clinical, supervisory, and management training needs of state facility and CSB direct care and support staff and advise the Department on issues related to training delivery strategies and training evaluation and competency assessment methods.

b. On an ongoing basis, implement specialized training programs to improve state facility and community-based public and private provider staff performance.

c. Establish a systemwide task force with membership from state facilities and CSBs to explore relationships with Virginia colleges and universities, including the establishment of joint teaching positions and promotion of joint research projects in FY 2003.

d. Strengthen partnerships with Virginia colleges and universities to offer internships and on-site training opportunities for psychiatrists, nurses, occupational therapists, physical therapists, and speech therapists.

e. Develop clinical training tracks in FY 2004 for positions that could be taught by state facility and CSB staff at local colleges and universities, ensuring that students are knowledgeable about the services system.

f. Develop and maintain Distance Learning Applications using video-teleconferencing equipment (polycom) in the provision of training at colleges or universities.

g. Partner with the University of Virginia's Institute of Law, Psychiatry and Public Policy to

continue to provide adult and forensic training, possibly through video-teleconferencing.

h. Continue affiliation with George Mason University to offer a certificate program in Applied Behavior Analysis for the state facilities and CSBs.

i. Explore opportunities for interagency training with Health and Human Resources agencies, CSBs, and private providers in areas of mutual interest, including:
   - Health Insurance Portability and Accountability Act (HIPAA);
   - implementation of human rights regulations;
   - models for serving individuals with limited English proficiency,
   - implementation of best practices in areas such as applied behavior analysis, emergency services, and case management;
   - treatment planning; and
   - discharge planning.

j. Develop, in partnership with Virginia colleges and universities, web-based training programs that provide state facility and CSB staff in rural areas access to Continuing Education Credits mandated for professional licenses.

k. Develop and maintain a central repository of human resources development and training resource materials and information.

l. Routinely address the training and development needs of Central Office and state facility employees in the Performance Planning and Evaluation process and centrally report this information for use in the developing training priorities and plans.

8. Foster the development of an early intervention work force that meets current practice guidelines in early intervention and appropriate caseload numbers.

Strategies:

a. Develop and implement Part C in-service training curricula, including short courses, distance learning programs, regional traditional training, and teleconferences for currently and newly employed personnel.

b. Develop guidance for early intervention services providers related to adequate and competitive salaries to ensure retention.

c. Continue to provide supports such as tuition assistance to assist employed personnel who do not meet the highest professional standards required by Part C to attain certification, licensing, or registration in a state-recognized profession.

d. Implement the early intervention assistant credential to support the recruitment of paraprofessionals from a wide range of cultural and educational backgrounds and provide on-the-job and in-service training and recognition of competencies.

e. Evaluate the feasibility of developing policy regarding the consistent use of paraprofessionals as service coordinators statewide in FY 2003.

f. Continue to work with Virginia colleges and universities to integrate various in-service training modules into pre-service training curricula for the various professions that work with early intervention services including occupational therapy, physical therapy, speech-language pathology, audiology, early childhood special education.

g. Develop strategies with Virginia colleges and universities to increase the number of professionals receiving pre-service training to work in early intervention in FY 2003.

h. Develop incentives to recruit minorities to work in early intervention services through Virginia colleges and universities and through other on-the-job training programs.

CARE UTILIZATION MANAGEMENT TO ASSURE APPROPRIATENESS OF SERVICES

For individuals receiving publicly-funded mental health, mental retardation, and substance abuse services system, the Department must:

- Assure the appropriateness of services provided to specific individuals,
- Promote positive outcomes for consumers and their families,
- Assure adherence of state facility and community services to professionally-recognized clinical practices, and
- Achieve operational market-based efficiencies in service delivery and management.

To achieve these goals, the Department will continue to develop internal expertise, processes, and procedures necessary to improve services system accountability and quality of care. The Department proposes to continue a variety of existing agency care utilization management efforts that are designed to:

- Improve the quality of services for consumers;
- Ensure consistent access across the state to services;
- Implement a centralized consumer and data management system for care management activities that is able to generate reports to state facilities, CSBs, and contracted providers; and
- Enhance accountability of the services system to consumers, family members, and state and local officials.

The Department also proposes to work with public and private service providers, consumer and family representatives, and other stakeholders to develop and assure the implementation of statewide professional practice guidelines and performance and outcome measures for services supported with state-controlled funds.

Long-range consideration might be given to the future incorporation of this care management function in the *Code of Virginia* as a Department responsibility and authorizing the development of care management regulations that would define authorization procedures for certain services with respect to quality of care, consumer satisfaction, and fiscal management. Such regulations would assure that the Department's care management activities comply with the intent of federal and voluntary standards for care management.

Inpatient Psychiatric Services Utilization Management

The Department has been successful in recent years in reducing the census of the state mental health facilities in large part through a concerted effort with CSBs to reduce admissions to these facilities. In the past two years, admissions to state mental health facilities have been reduced by 40 percent and census by 20 percent.

Despite this improvement, Virginia's system of mental health facilities still lags behind other health care delivery systems in its ability to manage inpatient service utilization. Effective

inpatient service utilization has implications for care in three critical areas: quality of care, access to services, and cost of care. Longer stays may compromise the quality of service to an individual by introducing factors such as increased dependency on an institutional system. In addition, in a time when there is considerable demand for available acute beds across Virginia, utilization management is critical to ensure that beds are available to individuals with the most critical needs. Finally, longer stays may result in loss of reimbursement if patients are held in units that are not appropriate to their service intensity needs because of a shortage of needed beds.

Effective inpatient service utilization can be significantly enhanced when a services system provides a greater range of service intensity options, such as step-down services, that can appropriately assist patients in rehabilitation to adapt to an environment outside of the hospital, while freeing high demand acute care beds. Such an approach could improve access to needed acute care beds and improve the appropriateness of care while reducing service utilization.

The Department funds acute psychiatric care in local qualified hospitals as well as in state facilities. In all cases, CSBs are the single point of entry to the public system and public funds. The Region IV (Central Virginia) Acute Care Project is an example of how these services are provided. The project began in September 1999 with an overall goal of establishing a community-based alternative to the provision of acute care in a state mental hospital. It uses collaborative principles and team-centered decision-making that includes Department, CSB, and state facility representation. An executive steering committee is responsible for the governance and evaluation of the project. A utilization management committee provides operational oversight and analysis of utilization trends and the use of resources. A regional authorization committee is responsible for clinical oversight, clinical evaluation care, and clinical indicators. The Department reviews, analyzes, and provides concurrent review data related to each admission to the project teams and the Department on monthly, quarterly and annual bases. The use of the funds is monitored by the Department and reconciled quarterly and annually.

In Region IV, the acute inpatient lengths of stay have been reduced significantly and more individuals have able to receive acute care than in prior years. In addition, there has been a reduction in the number of admissions to Central State Hospital. The CSBs, as the authorizing agents in the context of a regional approach, have demonstrated effectiveness in ensuring access and improving quality in acute patient care. Project findings suggest that the methodology would be applicable to other state facilities as well as local private hospitals in other regions. By decreasing the length of time in acute care, the state facilities could emphasize rehabilitation. Finally, as the demographics of the publicly-served population are more readily understood, adjunctive services can be designed to specifically address care needs of this population.

Management of Targeted Community Fund Pools

The Department has implemented several initiatives that support the purchase of individualized services (POIS) for populations with more severe disabilities, including:

- former patients from state mental health facilities whose discharges to the community are achieved through individualized services plans funded by the discharge assistance project (DAP),
- children and adolescents with serious emotional disturbance who are not mandated to receive services under the Comprehensive Services Act for Troubled Children and Youth (CSA) but who need individualized services,

- individuals with mental retardation who are not enrolled in the Medicaid mental retardation home and community-based waiver, but who still need services delivered through individualized plans of care, and
- individuals with mental retardation who are enrolled in the Medicaid mental retardation home and community-based waiver.

These initiatives are funded differently than traditional grant-funded services. While state general funds for these initiatives are still disbursed to CSBs prospectively on a semi-monthly basis, the use of these funds is managed through the review and approval of individualized services plans (ISPs) or plans of care (POC), utilization reviews of samples of those ISPs or POCs, and monthly reporting by the CSBs on these initiatives.

The Department's Office of Mental Health Services manages the DAP initiative. Within allocations of DAP funds to almost all CSBs (36 out of 40), CSBs develop ISPs for individuals who have been determined to be clinically ready for discharge from state mental health facilities. These plans are reviewed and approved by the Department, and CSBs use funds from their allocations to implement the plans. CSBs submit automated monthly individual and aggregate utilization reports on approved ISPs to the Office. Utilization of funds and delivery of services are monitored by the Office through these reports, and Department staff may conduct utilization reviews on some ISPs. CSBs are able, within their allocations, to reprogram funds if the costs of approved ISPs are less than projected, so that additional individuals may be discharged. The separate Discharge Assistance Project agreements that previously existed between the Department and individual CSBs were incorporated into the community services performance contracts in FY 2002.

The Department's Office of Health and Quality Care manages the child and adolescent purchase of individualized services initiative in a similar fashion. All CSBs receive allocations of state funds to serve children and adolescents with serious emotional disturbances who are not mandated to receive services under the CSA. Within those allocations, CSBs develop ISPs for these individuals and submit them to the Department for review and approval. CSBs then implement these ISPs, using funds from their allocations. CSBs submit automated monthly individual and aggregate utilization reports on approved ISPs to the Office. Utilization of funds and delivery of services are monitored by the Office through these reports, and Department staff may conduct on-site utilization reviews on some ISPs.

The Department's Office of Mental Retardation Services manages the non-MR Waiver POIS initiative the same way. All CSBs receive allocations of state funds to serve individuals with mental retardation who need individualized services, but who are not enrolled in the Medicaid Mental Retardation Home and Community-Based Waiver. Individualized plans of care (POC) are developed by the CSBs and preauthorized by the Department. Once these plans are approved, CSBs implement them, using funds from their allocations. CSBs submit automated monthly individual and aggregate utilization reports on approved POCs to the Office. Utilization of funds and delivery of services are monitored by the Office through these reports, and Office staff may conduct utilization reviews on some plans of care.

For all three of these initiatives, the Department's Office of Grants Management confirms that the funding requested for an individualized services plan or plan of care is available within the CSB's allocation of state funds prior to the managing office's approval of the ISP or plan of

care. Once an ISP or POC is implemented, the Office of Grants Management monitors the expenditure of funds against the allocation and balances of remaining funds through automated spreadsheets, using information submitted by the CSBs in their monthly reports. Data is collected at the individual consumer level and at the aggregate level. Summary allocation and utilization information is distributed to the managing offices on a monthly basis. The Department performs mid-year and year-end reconciliations, comparing expenditures with allocations for these initiatives and identifying balances of unexpended funds.

Thus, through these purchase of individualized services initiatives, the Department has implemented, on a limited basis, some of aspects of the managed system of care proposal contained in the 2000 - 2006 Comprehensive State Plan. This has allowed the Department to adopt and adapt those aspects of care management that will have the greatest impact on serving clearly identified subsets of some priority populations without incurring the significant costs often associated with managed care technology.

Medicaid MR Waiver Preauthorization

The Department's Office of Mental Retardation Services administers several critical functions in delivery of Medicaid MR Home and Community-based Waiver (MR Waiver) services, one of which involves the preauthorization of all waiver services. The preauthorization function has evolved as the interagency responsibilities of the Department and the Department of Medical Assistance Services (DMAS) have changed. However, the Department's preauthorization consultants have consistently reviewed each waiver recipient's social assessment and supporting eligibility documentation. The preauthorization consultants, each of whom is a Qualified Mental Retardation Professional (QMRP), also review the clinical appropriateness of all services included in each recipient's Consumer Services Plan.

During 2001, these preauthorization duties increased to require that all increases in services be evaluated by a higher standard, meaning that additional services or additional units of already approved services must be necessary to support the health and safety of the consumer and that documentation must be submitted to substantiate that need. Additionally, the preauthorization consultants were required to determine the overall cost of the plan and to report any increases authorized to DMAS.

The U.S. Centers for Medicaid and Medicare Services (CMS), formerly the Health Care Financing Administration (HCFA), has increased scrutiny of Waiver services in most states, including Virginia. Its concerns are focused primarily on the quality of care and particularly the medical and psychiatric needs of consumers receiving services. States have generally been required to intensify oversight of consumer health and safety in a number of areas, with one area being a more clinical, multi-disciplinary approach to the assessment and approval process.

The "*Draft Assessment Report: Virginia Medicaid Program: Home and Community-Based Waiver Services: Waiver for the Mentally Retarded,*" released by HCFA (now CMS) states that "Virginia must augment its staff charged with oversight of the waiver program with individuals who can identify and resolve medical and nursing issues associated with the population served under the Waiver." The recommendation, combined with several others related to consumer's health and medication management, will require that both assessment teams at the CSB level and preauthorization staff at the state level pay closer attention to the clinical and medical appropriateness of services authorized.

A new MR Waiver was submitted and approved for Virginia. Implementation of the new MR Waiver will begin in the fall of 2001. While the new MR Waiver offers many of the same services and some new ones, the need for developing greater quality assurance measures remains.

Goals, Objectives, and Strategies

Goal: Implement utilization management approaches that will improve quality and access to care.

Objectives:

1. ***Improve the utilization management practices in the state mental health facility system.***

   Strategies:

   a. Implement admission criteria in FY 2003 and continued stay criteria in FY 2004 in hospital programs that incorporate medical criteria such as severity of illness and intensity of service requirements and are based on accepted industry-wide standards.

   b. Implement requirements for daily progress note entries on acute hospital units that document both the severity of illness and intensity of services in support of continuation on the acute unit for another 24 hours, consistent with the standard that is used for utilization review by third party payers.

   c. Establish a mechanism to hold treatment teams in all state facilities accountable for non-certified days when the progress notes or clinical record do not document intensity of service need or severity of illness need.

   d. Update uniform procedures for reviewing and reporting utilization data to the Medical Director of Health and Quality Care.

2. ***Improve the quality of care by improving the timeliness with which assessments, treatments, and services are provided to patients in state mental health facilities.***

   Strategies:

   a. Implement requirements in FY 2004 that base continued certification for hospital stay on medical necessity rather than on a predetermined number of days in the hospital or by average length of stay for diagnosis for that facility.

   b. Develop practice protocols in FY 2005 to reduce the time frame for completion of the comprehensive treatment plan from seven to three calendar days.

3. ***Examine the need for additional options for service intensity in state mental health facility programs below the acute level.***

   Strategies:

   a. Study the advantages and disadvantages of various models of sub-acute programs based on the experiences of other public mental health systems.

   b. Study the feasibility of providing sub-acute services in unused state facility space, including an examination of the fiscal and regulatory implications of such action in FY 2004.

   c. Prepare recommendations for consideration by the Commissioner in FY 2004.

Goal: Promote regional utilization management of community-based acute psychiatric

services.

Objectives:

1. Continue to improve existing regional utilization management activities.

Strategies:

a. Provide training and education to CSB staff on the utilization of clinical criteria.

b. Monitor and evaluate data on utilization of services and trends associated with those services.

c. Monitor and evaluate contractor performance.

d. Provide technical assistance to contractors in the implementation of services.

e. Implement new adjunctive services as they are identified.

Goal: Maintain and enhance the Department's capacity to manage utilization of the purchase of individualized services initiative funds.

Objectives:

1. Maintain and refine the current management processes that enable managing offices to identify opportunities to utilize resources more effectively and completely.

Strategies:

a. Automate preauthorization and utilization review functions, as the Department implements the virtual private network, so that they occur on line in real time.

b. Develop internal data bases and reports, based on utilization review and financial reports, that will enable these offices to manage the utilization of POIS services when problems are identified.

c. Use this information and these processes to enable managing offices to transfer resources in exceptional circumstances, when there are repeated and unremediated problems with effective and efficient use of these resources.

d. Wherever possible, target the allocation of new resources for individualized services and supports, with clearly defined specific outcomes associated with all new funds, and hold providers accountable for these outcomes.

Goal: Improve oversight of MR Waiver recipient health and safety through a more clinical, multi-disciplinary approach to the assessment and plan of care approval process.

Objectives:

1. Continue to enhance MR Waiver preauthorization activities.

Strategies:

a. Review, in collaboration with DMAS, current quality assurance measures and practices to assure compliance with guidelines issued by CMS during FY 2002 and FY 2003.

b. Based upon this review, implement changes in the preauthorization process.

c. Provide training and technical support to providers around the State to enhance appropriate clinical interventions for MR Waiver recipients at the local level.

SYSTEM DESIGN AND INTEGRATION

Systemic Implications of Movement to a Market-Driven System with Expanded Use of Private Providers

Provider Development

Two of the over-arching and inter-related values of the publicly-funded mental health, mental retardation, and substance abuse services system are increasing choices for consumers and expanding opportunities for the private sector to provide services. Private provider participation in the services system has grown dramatically over the last four years. Two major factors influencing this growth have been significant increases in state-funded support for services, one of the Gilmore Administration's priorities, and especially the rapid expansion of Medicaid MR Home and Community-Based Waiver (MR Waiver) services.

Despite this significant expansion, two limiting phenomena have been apparent in this process: the absence of private providers in certain parts of the state and the need for private providers to offer more of particular types of services. For example, there are very few private providers in many rural parts of Virginia. Similarly, only a few providers offer community-based intermediate care facility services for individuals with mental retardation. Also, some of the newer and smaller providers have experienced difficulties in establishing sound operations in the rush to seize opportunities to offer scarce and greatly needed services. This has been evident with some new vendors of MR Waiver residential services.

Consequently, the development of private providers needs to be fostered and supported in various parts of the state. This includes encouraging existing private providers to expand their operations to other parts of the state, to begin offering other services, and to increase their current capacities. This also includes offering incentives to promote the development of new private providers. These initiatives should be joint efforts by the Department and the CSBs, working closely with the private provider community.

Conditions Affecting Private Provider Participation

A number of conditions have limited or reduced private provider participation in the publicly-funded mental health, mental retardation, and substance abuse services system.

- Medicaid State Plan Option and MR Waiver reimbursement rates, for the most part, have not been adjusted in over 10 years. In some areas of the state, Medicaid fees reportedly do not cover the cost of providing services; consequently, private providers are not able to offer those services on an economically sustainable basis.
- Third party insurance coverage for services has decreased with the shift to managed health care, in terms of services covered and the amounts of services allowed.
- A significant proportion of consumers either have little or inadequate health insurance coverage or may be unaware of available health benefits.
- Information about potential private providers may not be readily available to CSBs when their staffs are developing individualized services plans.
- Information about how to participate in the public sector may not be easy to obtain for private providers.

- There is perceived or actual resistance at some CSBs to expanding opportunities for private providers. Instead, these CSBs continue to funnel existing and new resources into their own direct operations.
- There is a perceived or actual resistance by some private providers to serving CSB consumers, because of the severity of their disabilities or misunderstandings about effective treatment modalities.
- Market forces have led to shifts in private sector service provision, despite the obvious and significant public sector needs for particular services. A clear and immediate example of this condition is the marked reduction in local private psychiatric inpatient hospital beds available to CSBs and the Department. This is a statewide phenomenon. Some providers have ceased offering this service due to inadequate reimbursement rates; others have converted their inpatient beds to other uses, such as Comprehensive Services Act residential beds, which may be less costly to operate and more easily reimbursable.
- Like public providers, the private sector is experiencing increasing difficulties in recruiting and retaining qualified staff, including professionals, such as nurses and other clinical staff, and para-professionals, such as residential aides and personal care staff.
- The large capital cost sometimes associated with the implementation of new services, particularly residential services, may inhibit private sector participation.
- Finally, the significant start up costs, such as staff recruitment and training, equipment purchases, acquisition of space, and operating at less than full capacity during ramp up that are often required to initiate a new service may make it difficult for smaller providers to do so, limiting their participation in the publicly-funded services system.

Care Coordination

Care coordination has always been an essential, core function and responsibility of CSBs, which serve as the single points of entry into the publicly-funded mental health, mental retardation, and substance abuse services system. *The Report on the Roles and Responsibilities of Community Services Boards for the Provision of Care Coordination, Case Management, and Services to Individuals with Mental Disabilities* (December 15, 2000) discusses care coordination in depth and offers recommendations on enhancing this function. Care coordination is becoming even more important to ensuring that consumers receive the services that they need, with the proliferation of private providers, the fragmentation of the services system that has occurred in some areas with the advent of managed physical health care, and the erosion of third party coverage for services. The increased emphasis on CSB predischarge planning, described elsewhere in this Comprehensive Plan is a clear example of efforts to enhance and systematize critical care management functions of the CSBs.

Oversight of Services Not Funded by the Department

While CSBs are the single points of entry into the publicly-funded services system, many of the services that their consumers receive are not funded by the Department or the CSBs. A prime example of this situation is the MR Home and Community-Based Waiver. More than half of the services funded through the Waiver are offered by private providers that often have little or no contact or clear relationship with CSBs. Additionally, it is often difficult for CSBs to monitor and oversee care and services provided to consumers by assisted living facilities (ALFs), since

ALFs are not licensed or funded by the Department and are not funded by CSBs. Another example is vocational or employment services that CSB consumers may be receiving, but which are funded by another agency, such as the Department of Rehabilitative Services. In many of these situations, when the service is not funded or licensed by the Department or funded by the CSB, human rights and licensing protections are not available to consumers in those services.

Relationships with Other Systems Providing Services or Supports

The values and principles for policy articulated by the Secretary of Health and Human Resources include: *"Boosting the individual's independence and self-sufficiency and discouraging dependency and entitlement."* The Hammond Commission on Community Services and Inpatient Care, in its 1998 interim report, emphasized, among other shared values: *"collaboration among the people served, their families and advocates, care providers, payers, and federal, state and local governments; community services to enable people with mental disabilities to lead independent lives in a community; and, public-private partnerships."*

These principles and values form the foundation of and are embodied in the Department's collaborative linkages, partnerships and activities with the Department of Housing and Community Development (DHCD), Department of Rehabilitative Services (DRS), the Department of Medical Assistance Services (DMAS), the Department of Social Services (DSS), the Department for the Visually Handicapped (DVH), the Department for the Deaf and Hard of Hearing (DDHH), the Department of Education (DOE), the Virginia Employment Commission (VEC), the Department for the Rights of Virginians with Disabilities (DRVD), the Virginia Housing Development Authority (VHDA), consumers, family members, advocates, and public and private providers to enhance consumers' access to medical services, housing, primary health care, and employment services. Following are descriptions of major interagency collaborative activities.

Medicaid

In 1990, the General Assembly directed the Department of Medical Assistance Services (DMAS), in cooperation with the Department, to develop and submit to the federal Health Care Financing Administration (HCFA) for approval:

- A mental retardation home and community-based waiver as an alternative to institutional placements, and
- Amendments to the State Medical Assistance Plan to provide Medicaid coverage for existing and expanded community services to persons with mental disabilities who need individualized services but not an institutional level of care (State Plan Option Services).

The Appropriation Act further directed that, upon approval of the waiver and amendments, all CSBs would participate in these programs to assure continued funding of state-supported services. The 1990 Appropriation Act also required that the Department reduce the state general fund appropriation for CSBs by $12 million in FY 1991, replacing these state general funds with federal Medicaid dollars. The original state general fund Medicaid match for covered State Plan Option and MR Waiver services was taken from the Department's appropriation and transferred to the DMAS appropriation. This practice, which differs from how matching funds are provided for other Medicaid-covered services in Virginia, continued until July 1, 2001. Now, these matching funds are provided in the DMAS appropriation. Today, all 40 CSBs participate in the

MR Waiver and provide services covered under the State Plan Option.

Following HCFA approval, the State Medical Assistance Plan was amended to cover specific mental health and mental retardation services. Covered mental health community services include intensive in-home services for children and adolescents, therapeutic day treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention, case management, intensive community treatment, crisis stabilization, and mental health support services. Community mental retardation services covered under the MR Waiver include residential support, day support, supported employment, personal assistance, respite care, environmental modification, nursing services, assistive technology, therapeutic consultation, and crisis stabilization. Mental retardation case management services are covered under the State Plan Option. The 1990 Appropriation Act identified substance abuse targeted case management, day support, methadone detoxification, and methadone maintenance to be added. However, no substance abuse services were added until the 1997 amendments. Then, substance abuse residential and day treatment services for pregnant and postpartum women were added.

The 1998 Appropriation Act required the Department and DMAS to study the potential expansion of Medicaid coverage for substance abuse services. This study described several other states= use of Medicaid to help cover the cost of providing specific substance abuse services, including crisis intervention, case management, hospital-based and non-hospital detoxification, outpatient, day treatment, methadone, and residential services. It provided specific estimates from William M. Mercer, Inc., a national actuarial firm with experience in this area, on the potential cost of providing Medicaid coverage for certain substance abuse services.

The 2000 General Assembly added matching funds to DMAS to provide additional substance abuse services. However, given the ensuing budget situation, the status of these matching funds is unclear. To date, DMAS has not promulgated regulations for these services. When regulations are promulgated, Department staff will be available to provide assistance in developing provider manuals, establishing rates, and other related implementation tasks. The same budget amendment required the Department to propose a model for tracking cost savings produced by using Medicaid funding (See *Medicaid Coverage for Substance Abuse Treatment: A Process for Evaluating Cost Benefits and Cost Offsets, October, 2000*). The first report is due to the Governor in the summer of 2003 so that the information would be available to assist budget development for 2004. However, if regulations are not promulgated in time to provide services during the year, the report will focus exclusively on substance abuse services to pregnant and postpartum women.

The 2000 General Assembly also approved budget language transferring responsibility, effective July 1, 2000, for locating and managing MR Waiver match money, as well as maintenance of the list of those waiting for MR Waiver services from the CSBs to DMAS. A joint emergency review committee comprised of Department and DMAS staff was established as a vehicle to bring new consumers onto Waiver. The agencies also heightened scrutiny for health and safety justification for requested enhancements to existing Waiver plans of care.

While DMAS remains the single state agency responsible to the U.S. Centers for Medicare and Medicaid Services (CMS) for oversight of all Medicaid-funded services, the Department plays a critical role in provider development, education and training of providers, and preauthorization of Waiver services. To an increasing degree, the Department is an integral partner in developing quality assurance measures and provider oversight. In accordance with an interagency agreement, the partnership between DMAS and the Department related to the

administration of the MR Waiver is intended to assure that:

- recipients of Medicaid-reimbursed community-based mental retardation services meet eligibility requirements;
- providers are aware of standards, regulations, and policies governing their operation;
- providers are afforded opportunities to receive information regarding program expectations;
- Virginia is proactive in assuring that the delivery of Medicaid-reimbursed community-based services are consistent with CMS expectations; and
- Medicaid-reimbursed community-based mental retardation services are appropriate for supporting Virginia residents in community living.

In the fall of 2000, an MR Waiver Task Force, comprised of consumers and family members, CSBs, private providers, advocates and representatives of DMAS and the Department, was convened to identify desired modifications in the Waiver in preparation for the development of a new MR Waiver application to CMS. As a result, application was made in April 2001 to CMS for a slightly modified Waiver, with the intent of making more significant changes in the form of a modification to the application in the future. An updated MR Community Service Manual (based on the existing application and regulations) was disseminated in May 2001. Training on the content of changes in this manual was conducted in advance in the fall of 2000. The Department is continuing to work with DMAS to develop regulations and a policy manual to be based on the CMS-approved application.

One major change in the new Waiver that came as a result of CMS's recommendations from their 1999 audit is the phasing out of DSS licensed assisted living facilities (ALFs) as providers of congregate residential support services. The Department's Offices of Mental Retardation Services, Licensing, and Human Rights conducted joint training around the state in August 2001 to prepare these providers for the change. All three offices will continue to work with these providers over the course of the next year to effect a smooth transition for MR Waiver consumers by September 15, 2002. At that point, any ALFs providing congregate residential support services will be licensed by the Department.

During FY 2001, a workgroup convened by DMAS met to recommend revisions and improvement to the Medicaid regulations and the provider manual for community mental health rehabilitation services. The workgroup included Department and DMAS staff, CSB and private provider representatives, and consumer and family advocates. This group achieved consensus on numerous substantive changes to the regulations and provider manual that should make the services more accessible, flexible, and appropriate for Medicaid recipients. While this activity did not increase the number of services that are part of the benefit package, the resulting changes were responsive to the concerns and issues brought by the workgroup. The workgroup will reconvene to consider changes to the regulations and provider manual for mental health case management services.

Historically, Virginia has not taken advantage of opportunities used by many other states to offset state revenues and maximize options available under the Medicaid program to expand critically needed services that could be covered under Medicaid. Although Virginia has increased the number of covered mental health and mental retardation services and has added a limited number of substance abuse services, Medicaid coverage could be expanded for certain

mental health services that are either currently supported in large part with state general funds or are provided at a higher cost in state mental health facilities. Two potential areas to expand Medicaid coverage follow.

- Programs of Assertive Treatment (PACT) teams, which provide intensive treatment, rehabilitation, and support services that reduce state hospital utilization. A number of states cover PACT teams in their State Medical Assistance Plans as a discrete service and CMS recently sent a letter to all State Medicaid directors encouraging them to consider this option. As these teams are implemented, additional state savings would be realized through reduced state hospital utilization. Virginia's experience with the existing PACT teams documents significant decreases in state facility bed utilization.

- Gero-psychiatric Residential Services, which provide specialized, post-acute psychiatric care for elderly individuals and adults with serious mental illnesses. Currently, these individuals remain in state hospitals even after they are stabilized because they require a level of services that is beyond the capacity of nursing homes to provide. As these specialized programs are implemented, state savings would be realized through reduced state hospital utilization.

Additionally, DMAS could provide additional state general funds for match to increase access to existing Medicaid mental health services for children and adolescents with serious emotional disturbance, particularly intensive in-home services, residential treatment services, treatment foster care, and acute psychiatric services. In-home services are designed to prevent family crises by providing crisis treatment, individual and family counseling, case management, and 24-hour per day emergency response. Residential treatment services and treatment foster care prevent hospitalization by providing the least restrictive treatment within a small group or family setting. Consideration might also be given to potential future Medicaid service expansion for this population in areas such as crisis stabilization, respite care, family support, and case management.

Recognizing the importance of Medicaid funding for a range of current and potential mental health, mental retardation, and substance abuse services, the Department and DMAS need to work closely together to:

- Complete current initiatives to implement the new MR Waiver and expand covered substance abuse services; and

- Explore additional ways to maximize opportunities to realize cost savings to the Commonwealth by expanding federal funding for community mental health, mental retardation, and substance abuse services.

Both the Department and DMAS need to give priority attention to developing a plan and seeking funding necessary for the phased introduction of new MR Waiver slots in order to respond to the service needs of individuals who are currently on the Waiver waiting lists for services.

Successful implementation of the new MR Waiver and expansion of MR Waiver slots will depend upon the availability of willing services providers. Community providers are finding that current Medicaid reimbursement rates are not adequate to meet their capital and labor costs. These providers are finding it increasingly difficult to recruit and retain qualified staff. The Department and DMAS need to work together to ensure that current Medicaid reimbursement rates for MR Waiver and State Plan Option services reflect the actual costs of doing business.

Social Services

The *Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996* brought profound changes to federal welfare policy making welfare assistance temporary and employment the goal. At the national level, substance abuse and dependence were recognized as major barriers to obtaining and maintaining employment among "hard-to-employ" Temporary Assistance to Needy Families (TANF) recipients. As part of welfare reform, states have been strongly encouraged to develop comprehensive and innovative approaches to providing substance abuse services for their TANF recipients through partnerships with other agencies and the flexible use of federal and state funds.

The Department's Office of Substance Abuse Services has entered into an agreement with the Department of Social Services (DSS) and the Department of Rehabilitative Services (DRS) to provide services that promote the long term well-being and employment needs of "hard to employ" TANF recipients with an identified substance abuse problem or mental health disability. Three CSBs (Richmond Behavioral Health Authority, Blue Ridge Behavioral Health and Norfolk CSB) were selected through a competitive process to provide family-centered, community-based substance abuse assessment and referral services and linkages to employment services on-site at their local departments of social service. The specific strategies of this project are to:

- Identify TANF recipients with substance abuse or mental health problems;
- Promote treatment and recovery services, along with specialized employment services, for TANF recipients;
- Provide wraparound support services to individuals and their families;
- Facilitate access to substance abuse and mental health treatment and services through creative linkages and partnerships; and
- Combine welfare reform's "work first" strategy with the flexible use of policy to support substance abuse treatment.

Housing

In an ongoing effort to promote, enhance, and develop housing opportunities for individuals receiving mental health and substance abuse services, the Department has maintained collaborative linkages, partnerships and activities with the Virginia Housing Development Authority (VHDA), the Department of Housing and Community Development (DHCD), the Virginia Interagency Action Council on Homelessness (VIACH), the Virginia Housing Study Commission, CSBs, and public and private housing providers.

There are two primary barriers to the provision of housing for adults with mental disabilities: availability and affordability. The 2000 *"Study of Funding for Housing Serving People with Disabilities"* (Senate Document No. 12) reports that people with disabilities in Virginia experience difficulties in finding decent, affordable housing. Often, suitable housing is not available where consumers want to live. In most areas, housing assistance is unavailable or waiting lists are too long.

In 2001, DHCD and VHDA held a series of housing forums across Virginia to solicit public input on current housing needs in each region of Virginia. Representatives from CSBs were present at most forums and provided important feedback about the housing needs of their

consumers. These forums were conducted as part of a housing needs assessment project that the two agencies are carrying out under the direction of the Secretary of Commerce and Trade. In every regional forum, participants cited a lack of affordable housing; increased demand for special needs housing; and a need for education at the consumer, provider, and community level.

Virginians with disabilities who receive only Supplemental Security Income (SSI) are virtually excluded from the regular rental market of decent, safe housing because of cost. Since 1998, housing costs in Virginia have increased 17.2 percent while SSI income in Virginia has increased only 3.6 percent. The HUD Fair Market Rental (FMR) for a one-bedroom unit ranges from a low of $365 in the southern and western Virginia to a high of $735 per month in northern Virginia. Affordable housing is generally defined as housing costs that are at or below 30 percent of gross household income. However, for people on SSI, who receive $530 per month, a one-bedroom unit at FMR costs between 69 percent and 139 percent of monthly income in Virginia.

The lack of affordable housing has been cited as the primary cause of homelessness in the U.S. Poor people who have a mental disability are at increased risk for homelessness. The number of Virginians with serious mental illnesses estimated to be homeless or at risk of homelessness is between 12,000 and 20,000. This estimate is based on studies that project between 5 percent (Task Force on Homelessness, 1992) and 8.4 percent (Culhane, 1997) of adults with serious mental illness will become homeless each year. This population is often disengaged from mental health services and in great need of housing and support services.

The Department administers the federal Projects in Assistance for Transition from Homelessness (PATH) program, which funds outreach and engagement services for persons who are homeless and have serious mental illness in 18 sites across the state. In FY 2001, Virginia was awarded $743,000 in PATH funds. While some housing services, such as one-time rental assistance and help in locating housing, are eligible PATH expenses, the focus of PATH services continues to be on outreach and engagement with mental health services. In spite of significant match provided by project agencies, PATH services are only able to reach approximately 65-70 percent of the estimated population in need of services.

While there is a recognized and growing need for intensive and supervised housing options, most consumers need supportive housing rather than intensive or supervised residential services. These consumers are able and prefer to live independently in existing community housing, provided that they are able to access an array of community-based services. A recent study of the impact of supportive housing programs for persons who were homeless and had serious mental illness revealed that people placed in supportive housing programs in the sample experienced marked reductions in shelter use, hospitalizations, length of stay when re-hospitalized, and incarceration. Further, the cost of the supported housing programs was almost entirely offset by the savings realized in the reductions noted. (Culhane, D. Metreaux, S. and Hadley, T.)

Oxford House, Inc., is a network of self-run, self-supported recovery houses. This system fosters democratically-run group housing where individuals are able to live a clean and sober lifestyle in a safe and affordable environment. When an individual is accepted into the house, there is no time limit on how long he or she can live there, but use of alcohol or drugs or non-payment of rent will result in expulsion. Presently there are 44 Oxford Houses in Virginia with a total of 374 beds, 304 for men and 70 for women. Oxford House, Inc., has contracted with the Commonwealth to provide loan management and technical assistance to Oxford Houses in Virginia. Oxford House provides this service to other states as well. The expectation is that the

Commonwealth of Virginia will continue to contract with Oxford House, Inc., or another contractor, to continue the provision of providing housing, for persons in recovery, statewide.

State and local efforts are being made to provide affordable housing for people with disabilities. In FY 1999 and FY 2000, the Governor and General Assembly provided $6.5 million annually for mental health residential and support services, of which CSBs budgeted 32 percent for discharged patients and 21 percent for rental assistance. An additional $1.4 million was added in FY 2001, of which 23 percent was budgeted for rental assistance.

In FY 2000, 40 percent of VHDA Section 8 participants and 25 percent of local Public Housing Authority program participants were disabled. Increased levels of production of new affordable rental units through the Low Income Housing Tax Credit (LIHTC) Program are resulting in new rental housing units throughout the state.

Primary Health Care

There are now a number of published studies that show that people with serious mental illness have higher rates of physical disability, significantly poorer health, and higher mortality rates than the general population. This is due in part to low income, a lack of health insurance, and the lack of access to adequate primary health care. The Virginia Primary Care Association defines access as the opportunity to receive the services of general practice physicians (family practice, internal medicine, pediatricians) or other primary care providers, such as nurse practitioners or physician's assistants, and services such as lab tests, x-rays, and medications.

Although the relationship between mental illness, physical health and disability, and poverty are not clearly understood, research shows that poverty and the lack of access to primary health care are significant factors in both poor health and mental illness (Mauksch et al, 2001). The picture is further complicated by the lack of understanding of the special needs of this population among many primary care physicians. Such needs may include spending more time with the person to help him understand the treatment regime, enlisting the help of a family member or friend of the patient, referrals to social service agencies to provide for transportation for clinic visits, and referrals to nutritionists and other specialists to improve the person's health behaviors. This inability to recognize the special needs of persons with serious mental illness may lead to further impairments, increased use of medical services, and higher costs (Golomb, et al, 2000).

The literature shows that when persons with mental illness are given choices about the service delivery models they prefer, they consistently choose a model that provides for ongoing collaborative care between primary care and mental health providers. Collaborative care includes the following key elements (White, 1997).

- Close proximity between the primary care physician and the mental health provider is critical to improved care. Close proximity, even one day a week, allows practitioners to communicate and integrate their care strategies, and it reduces the transportation burden that creates barriers to access for many people with mental illness.
- Establishing relationships between primary care physicians and mental health providers is key to fostering collaborative working relationships. Referrals and ongoing communication are more likely to occur among providers who know each other and have established a positive working relationship. Service systems and physician leaders can promote such relationships through professional organizations, by sponsoring training programs that are of
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interest to both groups, and by creating opportunities that facilitate such relationships, for example through joint faculty appointments and psychiatric residency placements for medical students.

- Sharing records, with the consent of individuals receiving treatment, facilitates collaboration. When primary care physicians and psychiatrists both have access to records, there can be more consistency in treatment. This, of course, is facilitated when both practitioners are located in close proximity to each other, preferably in the same building.

In many areas of Virginia, the most significant barrier to primary health care is the lack of providers in the individual's community. The Virginia Primary Care Association is devoted to improving access to primary care by increasing the number of practitioners in underserved areas of the state. One of the goals of their *Campaign for 100% Access and Zero Health Disparities* is to provide primary care to uninsured citizens of the Commonwealth within a reasonable travel distance. They do so through their Scepter program, which places medical students and other primary health care professional students in Community Health Centers for two to six week rotations; through organized recruitment efforts; and by working with communities to develop solutions for improving access.

Accessing primary health care is a problem for people with mental retardation of all ages as evidenced by the Surgeon General's recent efforts to promote study of and develop action steps in response to this issue. Some access issues involve the inability of people with mental retardation to communicate pain, symptoms or emotions through verbal channels, only through behaviors. Primary care medical practitioners are not educated in how to understand or treat people who cannot articulate symptoms or source of their pain or illness. As the likelihood of physical and cognitive complications increase with age, the need for primary care practitioners will increase equally. They may require the assistance of professionals in the field of mental retardation to help them distinguish between challenging behaviors that are the individual's only means of communicating pain or dissatisfaction versus a manifestation of psychosis.

According to a May 2000 (Columbia University, National Center on Addiction and Substance Abuse-CASA) survey of primary care providers and physicians, nine out of ten (94 percent) primary care physicians fail to diagnose substance abuse when presented with symptoms of alcohol abuse in an adult patient, and 41 percent of pediatricians fail to diagnose illegal drug abuse when presented with a classic description of a drug abusing teenage patient. The survey revealed that physicians are missing or misdiagnosing a patient's substance abuse for several reasons: lack of adequate training in medical school, residency, or continuing medical education courses; skepticism about treatment effectiveness; discomfort discussing substance abuse; time constraints; and patient resistance.

The study also revealed that physicians feel unprepared to diagnose substance abuse and lack confidence in the effectiveness of treatment. Only a small percentage of responding physicians consider themselves to be "very prepared" to diagnose alcoholism (19.9 percent), illegal drug use (16.9 percent) or prescription drug abuse (30.2 percent); whereas they feel "very prepared" to identify hypertension (82.8 percent), diabetes (82.3 percent), and depression (44.1 percent).

Since substance use disorders are often chronic conditions that progress slowly over time, primary care clinicians (physicians, physician assistants, and advanced practice nurses), through their regular, long-term contact with patients, are in an ideal position to screen for alcohol and drug problems and monitor each patient's status. (SAMHSA-CSAT Treatment Improvement

Protocol #24). Furthermore, studies have found that primary care clinicians can actually help many patients decrease alcohol consumption and its harmful consequences through office-based interventions that take only 10 or 15 minutes (Kahan et al., 1995; Wallace et al., 1988)

Even though screening and limited treatment of substance use disorders do not require a large time investment, primary care clinicians are already overwhelmed by the demands of their clinical practice, and a practical approach is needed: one that recognizes the time and resource limitations inherent in primary care practice and that offers a series of graduated approaches that can be incorporated into a normal clinic or office routine. (SAMHSA-CSAT Treatment Improvement Protocol #24).

In 2000, the Department participated in a regional summit co-sponsored by the U.S. Substance Abuse and Mental Health Services Administration and the Health Resource and Services Administration, Bureau of Primary Health Care, National Health Service Corps. The summit focused on "Ensuring the Supply of Mental and Behavioral Health Services and Providers." Out of this summit, individual and cross-state action plans were developed. The Virginia State Action Plan identifies the following needs for practitioners:

- Major training of practitioners in recognizing and treating psychiatric disorders;
- Understanding resources and integrating with primary care providers and mental health and substance abuse services providers; and
- Screening tools.

In the plan, the following requests for technical assistance were made:

- Curriculum planning for cross training primary care physicians and psychiatry residents;
- Telemedicine and telepsychiatry;
- Establishment and funding of a clearinghouse of resources and information;
- Public access to linkages with academic information resources on funding;
- Identification on internet sites that offer information on psychiatric diagnoses and psychopharmacology that providers can access for current, up-to-date information.

Vocational Assistance

Adults with a serious mental illness and youth with serious emotional disturbances face challenging obstacles to obtaining and maintaining competitive employment. These include interruptions in education and employment that may be caused by symptom onset and exacerbation; pervasive stigma; and the limited availability of vocational programs that incorporate state of the art "best practices" in employment services and supports for this population.

These obstacles, coupled with a fear of losing health insurance coverage, the most often cited obstacle to employment by individuals on SSDI or SSI, especially coverage for prescription drugs, and the lack of accurate information about current complex work incentives for consumers, case managers, and service providers all combine to form significant barriers to improving consumers' self-sufficiency and independence. Complicated funding streams and varied and frequently uncoordinated vocational assistance programs and approaches taken by multiple agencies add to the difficulties consumers, staff, and providers encounter when addressing employment-related concerns.

The Department intends to address many of these barriers through continuing and broadening its collaboration and coordination with multiple federal and state agencies, entities of local government, universities, public and private providers, consumers, family members, and advocacy groups through implementation of several diverse but coordinated initiatives.

Joint mental health and substance abuse employment initiatives between the Department and the Department of Rehabilitative Services (DRS) focus on specialized mental health programs in 12 CSBs and substance abuse programs in 19 CSBs to bring about greater consumer community integration and vocational success. Vocational assistance services should include, but not be restricted to receiving job placement and follow-up services; vocational training and education, as appropriate; physical and psychological examinations; maintenance and transportation assistance; interpreter and note-taking services, when needed; telecommunication, sensory, and other technological aids and devices; occupational licenses, tools, equipment, stocks, and supplies, as appropriate; and supported employment services to assist in job placement, job site training, and follow-through.

- Vocational assistance mental health services are provided by DRS counselors who are placed within the CSB psychosocial rehabilitation program. These counselors cross train staff and participate in joint planning and pursuit of federal grant opportunities to increase employment options for people with mental disabilities.
- Vocational assistance substance abuse services are provided through an interagency agreement with DRS that funds twenty-one DRS counselors who provide co-located clinical and employment-oriented programs that address employment and community stability through vocational development, work habits, job readiness, and employment follow-along services, along with coordinated CSB clinical and social supports.

The *Ticket to Work and Work Incentives Improvement Act of 1999* (TWWIIA) and subsequent New Freedom Initiative resulted in new grant opportunities for states to improve employment outcomes for people. The Department has collaborated with DRS and DMAS on two significant grant application initiatives. Up to $500,000 for FFY 2002 has been awarded to DMAS for the first application, *Virginia's Infrastructure Grant Proposal*. Activities will include: designing, implementing, and testing the impact of Medicaid Buy-In options and improving the utilization of existing work incentives available through various Social Security Administration programs. Goals of the second application (outcome status is pending), the *Virginia Systems-Change Project to Enhance Employment Outcomes for Individuals with Psychiatric Disabilities,* include:

(a) designing and implementing an interagency structure that integrates employment, public assistance, vocational services, and health care programs to effectively enhance employment outcomes for youth and adults with psychiatric disabilities;

(b) designing and implementing innovative practices that enhance employment opportunities for youth and adults with psychiatric disabilities; and

(c) designing and implementing a comprehensive, ongoing program of training and technical assistance that will improve the quality of employment-related services and supports provided to youth and adults with mental disabilities.

Linkages with Local Government and Community Services Boards

Local Governments

The 134 cities or counties in Virginia continue to be vital members of the state-local partnership that enables the provision of community mental health, mental retardation, and substance abuse services to more than 200,000 Virginians annually. The Department needs to communicate with local governments about their concerns and ideas, such as potential changes in the state-local government partnership that could enhance service quality and effectiveness and provider accountability and efficiency. As demands for services continue to grow beyond the capacity of the current services system to meet them, and as related requirements for more effective management and coordination of services proliferate, new and innovative approaches need to be considered that preserve the strengths and advantages of the current publicly-managed system while responding to these new demands.

Increasingly, CSBs will be held accountable for achieving defined performance and outcome standards, implementing continuous quality improvement goals, and adhering to professionally-recognized clinical practices. They also will be held accountable for assuring the effective and appropriate utilization of public resources, including state facility beds. One approach that could address some of these expectations would be implementing community services performance contracts that include limited risk with financial incentives and disincentives associated with these performance expectations. This limited financial risk would not create any new entitlement or requirement beyond the parameters of the community services performance contract. Even this limited financial risk, however, might be more than some local governments would be willing to accept. If given the opportunity, some local governments might opt out of their current relationship with the Department. For these communities, the Department would consider contracting with another health care organization to perform those functions currently performed by those CSBs.

System Leadership Council

The System Leadership Council evolved from the FY 2001 performance contract negotiations, reflecting a desire to have a mechanism embedded in the contract to provide continuity and a means for enhancing communications and addressing and resolving systemic issues and concerns. The Department, under the aegis of the community services performance contract, established the System Leadership Council in August 2000. The Council includes representatives of CSBs; state facilities; local governments; the State Mental Health, Mental Retardation and Substance Abuse Services Board; and the Department. The performance contract states that the System Leadership Council shall, among other responsibilities:

- identify, discuss, and resolve communication issues and problems;
- examine current system functioning and identify ways to improve or enhance the operations of the system; and
- identify, develop, propose, and monitor the implementation of new service modalities, systemic innovations, and other approaches for improving the accessibility, responsiveness, and cost effectiveness of the publicly-funded mental health, mental retardation, and substance abuse services system.

The Council should serve as the coordinating mechanism to discuss issues and problems from

a system perspective in a calm environment to reach as much agreement as it can, providing continuity, enhanced communication, and consistency over time. A plethora of groups are working on a variety tasks and issues. Groups include the Quality Care Council; Mental Health Planning Council; VACSB MH, MR, and SA Councils; POMS Work Group; VACSB Administration Committee; and VACSB/VALHSO Performance Contract Work Group. The Council should serves as a mechanism for integrating related activities among these groups.

The Council's work and recommendations may affect the organization and delivery of publicly-funded mental health, mental retardation, and substance abuse services in the Commonwealth. Accordingly, it is particularly helpful that local governments and CSBs are involved in this process. The Council has met six times in the past year. It has discussed a broad range of issues and supported a number of initiatives, among them, uniform statewide predischarge planning protocols, streamlining performance contract and reporting requirements, workforce and manpower issues, the MR Waiver, standardization in community services, community psychiatry, consumer choice and provider access, and aftercare pharmacy and medications issues.

Goals, Objectives, and Strategies

Goal: Encourage and facilitate greater private provider participation in the publicly-funded mental health, mental retardation, and substance abuse services system, with enhanced care coordination and service monitoring by CSBs, to increase consumer choices and quality of life.

Objectives:

1. ***Identify ways to increase the number of private providers participating in the publicly-funded services system and to expand the array of services they offer.***

   Strategies:

   a. Establish a small work group of affected stakeholders to identify and implement policies and actions that would encourage greater private sector participation. Stakeholders include consumers, their family members, the Department, state facilities, DMAS, CSBs, private providers, and local governments.

   b. Direct this same group to examine conditions that adversely affect private provider participation and identify solutions or ways to ameliorate those conditions.

   c. Urge DMAS to study current reimbursement rates for Medicaid State Plan Option and MR Wavier services and adjust them where warranted to encourage greater private sector participation in the publicly-funded services system.

2. ***Identify ways to enhance care coordination and service oversight by CSBs, including clinically necessary and responsible monitoring of non-contracted service providers, without inhibiting increased private service provision.***

   Strategies:

   a. Develop and implement uniform statewide admission criteria for state mental health facilities and for state mental retardation facilities in FY 2003, using a process similar to the one used by the Department to develop and implement the predischarge planning protocols.

b. Develop and implement uniform statewide preadmission screening protocols in FY 2004, using a process similar to the one used by the Department to develop and implement the predischarge planning protocols.

c. Develop and implement uniform statewide case management practice guidelines in FY 2004, using a process similar to the one used by the Department to develop and implement the predischarge planning protocols.

d. Establish a small work group of affected stakeholders to identify and implement policies and actions that would enable clinically necessary and responsible monitoring of non-contracted service providers, without inhibiting their participation in the publicly-funded services system. Stakeholders include consumers, their family members, the Department, private providers, CSBs, and the DMAS.

Goal: Increase interagency collaboration, cooperation, and coordination to enhance income assistance, housing, health care, education, and employment opportunities and outcomes for individuals with mental disabilities.

Objectives:

1. Reduce system and inter-agency barriers that hinder access to housing, health care, education, employment opportunities and outcomes for consumers.

Strategies:

a. Conduct forums in FY 2003 with DHCD, DMAS, DSS, DVH, DDHH, DOE, DRS, DRVD, VEC, VHDA, consumers, family members, public and private providers, and advocacy groups to identify cross-agency and agency-specific barriers to various services and support.

b. Continue inter-agency collaboration and initiatives that promote services and supports systems integration and decrease identified system barriers at the state and local levels.

c. Continue to collaborate with DRS and DSS in establishing effective community based resources and relationships with public and private providers to assist in screening, identifying, and treating TANF recipients with mental disabilities.

d. Continue to monitor the availability of collaborative grant applications, and, as appropriate, cooperate in applying for grants that will enhance service opportunities for individuals with mental disabilities.

Goal: Expand the availability of MR Waiver and State Plan Option services.

Objectives:

1. Successfully implement the new MR Waiver and State Plan Option services.

Strategies:

a. Jointly review and update the interagency agreement between the Department and DMAS to clarify and reaffirm the Department's role in policy and operations related to the MR Waiver and State Plan Option services and address the General Assembly's intent as expressed in Appropriations Act language

b. Jointly develop a multi-year plan and funding strategy for the phased implementation of additional MR Waiver slots to address documented waiting list demand.

c. Jointly review and update DMAS studies on MR Waiver and State Plan Option reimbursement rates to ensure that these rates are sufficient to recruit and retain quality providers in all areas of the State.

d. Jointly review the Mercer report on Medicaid-funded substance abuse services with services system stakeholders to identify strategies for expanding Medicaid-covered substance abuse services.

e. Jointly explore the feasibility of expanding Medicaid-covered mental health services to include PACT Teams, gero-psychiatric residential services, and additional child and adolescent mental health services.

f. Support DMAS efforts to seek funding for MR Waiver and State Plan Option services.

Goal: Maximize the use of all available housing resources to address the housing and community-supports needs of individuals receiving mental health, mental retardation, and substance abuse services.

Objectives:

1. Pursue funding resources and interagency collaborative responses to meet the housing needs of individuals receiving services during their transition to community living.

Strategies:

a. Provide ongoing assistance to CSBs and publicly-funded services providers in accessing federal resources to meet the housing and community-based supports needs of individuals receiving services.

b. Continue to provide information to CSBs about grants and other funding opportunities that provide resources to meet housing needs.

c. Work closely with the Virginia Housing Development Authority, the Department of Housing and Community Development, and other agencies to maximize the use of all available resources.

d. Investigate and, if feasible and appropriate, implement an ongoing interagency council, comprised of the Department, the Virginia Housing Development Authority, the Department of Housing and Community Development, and representatives of CSBs, local governments, and housing authorities, to build a strong partnership between state and local organizations with a responsibility for addressing housing needs and issues.

Goal: Expand and improve the existing network of Oxford Houses statewide.

Objectives:

1. Increase visibility and integration of Oxford Houses in communities.

Strategies:

a. Encourage existing Oxford Houses to expand outreach activities to the substance abuse recovery community.

b. Encourage existing Oxford Houses to strengthen their relationships with CSBs, substance abuse treatment programs, health care providers, homeless organizations, rehabilitation programs, and criminal justice programs (drug courts and post-incarceration).

c. Introduce the Oxford House self-run, self-supported recovery housing model to new communities across Virginia.

d. Work to strengthen Oxford Houses that are having difficulties or are on the verge of closing.

e. Provide technical assistance, on-site training, and regional workshops to Oxford Houses.

f. Place greater emphasis on the development of specialty houses, such as houses for adults with children.

Goal: Remove substance abuse problems as a barrier to obtaining and maintaining employment for TANF recipients.

Objectives:

1. Develop an interagency, community-based collaborative program aimed at coordinating and enhancing services to meet the extensive and multiple needs of TANF recipients who have an identified substance abuse problem.

Strategies:

a. Continue to work with CSBs to help them identify and provide services to "hard to employ" TANF recipients with an identified substance abuse problem or mental health disability.

Goal: Improve access to primary health care for person with serious mental illness, mental retardation, or substance dependence or abuse.

Objectives:

1. Identify opportunities to promote working relationships between primary care physicians and mental health professionals in community and state facility programs.

Strategies:

a. Identify training programs sponsored by the Department that would be of interest to primary care practitioners and mental health professionals and offer continuing medical education credits as an incentive for participation.

b. Establish certification requirements for behavioral consultation to assure a pool of qualified providers trained to observe behaviors of individuals receiving mental retardation services relative to their environment, diet, and activities that may help detect behavior "triggers" that stem from medical conditions.

c. Monitor the work of the Surgeon General in addressing primary health care for people with mental retardation.

d. Support a proposed project in Tidewater with the Virginia Beach CSB, Sentara (teaching hospital and direct care), and a Downs Syndrome group to develop a model of educating and providing primary care to people with mental retardation and assist the project to find a funding source.

e. Identify local grant funds for meetings, training programs, and other activities designed to promote close working relationships among primary care physicians and psychiatrists in the public behavioral health sector.

f. Identify physician leaders in the public behavioral health community who are motivated

to champion the development of relationships between the two groups through their professional organizations.

g. Host a series of meetings in FY 2003 between primary care physicians who have assumed leadership roles in their communities and CSB psychiatrists to explore the mutual benefits of relationships and collaborative arrangements. Based on these meetings, develop and disseminate to CSBs strategies for creating such collaborative relationships.

h. Continue to explore opportunities for collaboration with the Virginia Primary Care Association.

i. Explore funding opportunities and relationships that will facilitate the creation of linkages between the two systems of care.

Goal: Increase awareness among primary care clinicians about drug and alcohol use, abuse, and dependence (addiction); screening, assessment, and referral; and the effectiveness of substance abuse treatment services.

Objectives:

1. Provide primary care clinicians with information about periodic and routine screening of all patients for substance use disorders.

Strategies:

a. Orient primary care providers in the use of simple, standardized screening instruments such as the Alcohol Use Disorders Identification Test (AUDIT), the CAGE-AID questionnaire (CAGE adapted to include questions about drugs as well as alcohol), the TWEAK test for pregnant women, and the Problem Oriented Screening Instrument for Teenagers (POSIT).

b. Provide guidance on techniques for following up with patients who may have positive findings from screening, including conducting brief interventions to obtain additional information to assess the severity of suspected alcohol or drug involvement, identifying special medical and psychiatric considerations, and gauging the patient's readiness to change.

c. Provide information about how to refer consumers to CSBs or other providers for comprehensive substance abuse assessments and treatment, if indicated.

d. Provide information about brief, office-based, therapeutic interventions for patients who refuse referral for further assessment or treatment.

e. Educate primary care clinicians about the biological model of addiction, the chronic, relapsing nature of addiction, and the efficacy of substance abuse treatment, particularly when such treatment is provided with the support of family, friends, health and social service providers, and the community.

Goal: Reduce barriers to employment for youth and adults with mental disabilities.

Objectives:

1. Provide consumers, family members, case managers, and public and private vocational and employment-related service providers with accurate information on existing SSI and SSDI work incentives.

Strategies:

a. Continue to work with DSS, DRS, and DMAS to review utilization of existing SSI and SSDI work incentives in Virginia.

b. Identify issues that contribute to the underutilization of work incentives by individuals with a mental illness in FY 2003.

c. Develop and implement strategies to improve the use of existing work incentives by people with a mental illness in FY 2003.

d. Link mental health consumers and CSB case management and psychosocial rehabilitation services staff to recently awarded SSA contractors that will provide SSI and SSDI individualized benefits assistance planning.

2. Address consumer fears about the loss of health insurance and prescription coverage if earned income exceeds benefit thresholds.

Strategies:

a. Continue to work with DSS, DRS, and DMAS to review utilization of continuing Medicaid coverage for individuals on 1619 (b) status with the Social Security Administration.

b. Collaborate in the development of and disseminate information, resources, and draft letters for use by consumers and case managers to assure continuation of Medicaid as allowed by 1619 (b) when individuals' earned income exceeds SSI thresholds.

c. Obtain input from services system consumers, family members, advocacy groups, and public and private psychosocial rehabilitation and employment-related services providers on the design, implementation, and testing of a Medicaid Buy-In option for Virginia.

d. Collaborate with DRS, DMAS, mental health constituency groups, and others to establish and develop principles and methods for Medicaid Buy-In options.

Goal: Improve competitive employment opportunities and outcomes for youth and adults with serious emotional disturbances and serious mental illnesses.

Objectives:

1. Improve knowledge about state-of-the-art effective employment practices for youth and adults with mental disabilities.

Strategies:

a. Provide mental health psychosocial rehabilitation, vocational, PACT, and other providers with information and knowledge on approaches to supported employment and the individualized placement and supports model of employment services.

b. Link mental health providers with existing Internet web-based instruction and courses on supported employment principles, services, and supports.

c. Disseminate the *Technical Assistance Tool Kit on Employment for People with Psychiatric Disabilities* to public and private community mental health support services providers.

2. Expand the availability of state-of-the-art employment services and supports for youth and adults with mental disabilities.

Strategies:

a. Collaborate with the Rehabilitation Research and Training Center on Workplace Supports at Virginia Commonwealth University to develop and implement initiatives to improve the quality of existing employment-related services and supports provided to youth and adults with mental disabilities.

b. Continue to identify, and, as appropriate, collaborate on applications for federal grants that offer opportunities to develop and provide state-of-the-art employment services and supports.

c. Continue to measure employment status as an outcome in the Department's POMS system.

Goal: Improve the quality of vocational services provided to substance abuse consumers.

Objectives:

1. Enhance the relationship between DRS counselors and CSB clinicians and case managers.

Strategies:

a. Collaborate with DRS in establishing state-of-the-art employment programs and in increasing access to vocational assessments, job training and rehabilitation, and employment services and supports.

b. Support cross-training efforts between CSBs and DRS that promote a better understanding by DRS staff of the comprehensive nature of substance abuse treatment and by substance abuse staff of what DRS has to offer individuals receiving substance abuse services.

c. Provide additional technical assistance to CSBs and DRS staff, as appropriate.

d. Assist CSBs and DRS in providing better record keeping on interagency relationships and services provided to consumers.

e. Develop a standardized format and worksheet for on-site visits that will assure all CSB DRS counselors are adhering to same work expectations in FY 2003.

f. Enhance year-end evaluation to make it more qualitative and data more user-friendly for CSB and DRS staff.

g. Encourage information sharing and development through quarterly CSB/DRS meetings.

Goal: Facilitate and encourage communication with local governments regarding their roles and responsibilities in the publicly-managed mental health, mental retardation, and substance abuse services system.

Objectives:

1. Provide multiple opportunities for local governments to learn about and participate in decision making and monitoring of the Department's policy initiatives as it seeks to develop and implement a responsive, responsible, and accountable publicly-managed system of state facilities and community services.

Strategies:

a. Begin an ongoing dialogue with the Virginia Municipal League, the Virginia Association of Counties, and the Virginia Association of Local Human Services Officials on local

government issues and concerns about the publicly-funded mental health, mental retardation, and substance abuse services system.

b. Continue and enhance the involvement of local government representatives on the System Leadership Council.

c. Convene a state level policy work group in FY 2003 to examine current roles and responsibilities and possible future options and alternatives for local governments in the publicly-funded mental health, mental retardation, and substance abuse services system. This could include consideration of a local government option to allow CSBs to enter into a limited risk performance contract with financial incentives and disincentives associated with the utilization of state facilities and the achievement of performance and outcomes standards defined in the performance contract.

2. Continue the System Leadership Council to enhance communication with and participation by CSBs in system level policy deliberations and problem solving.

Strategies:

a. Provide support for System Leadership Council activities.

b. Identify ways to increase and broaden communication between the Council and the constituencies that members represent.

SYSTEM ADMINISTRATION

HIPAA Compliance Requirements

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) is changing the way healthcare is insured, documented, compensated, communicated, and audited. Signed into law by President Clinton August 21, 1996, HIPAA is intended to:

- significantly reduce healthcare fraud and abuse,
- enforce standards for patient identifiable health information,
- guarantee the privacy and security of identifiable patient health information, and
- assure health insurance portability for employed persons.

A major reason healthcare costs have been spiraling out of control is due to the fraud and abuse of healthcare claims. Studies show fraud accounts for hundreds of millions of federal dollars paid to providers for services to patients that were never performed. In other instances, it could be shown that healthcare professionals simply used the wrong code when billing for a specific procedure, which resulted in too great a reimbursement to the provider or too little. HIPAA aims to reduce the occurrences of fraud and abuse through the use of electronic transaction and code set standards. Studies have shown that the reason so many coding errors occur is because there are too many code sets for medical diagnoses and procedures. One count reports over 400 individual code sets are in use, which leads to confusion across the industry.

HIPAA has been enacted as part of a broad Congressional attempt at incremental healthcare reform. As stated in the regulatory language, "administrative simplification" is a chief HIPAA goal. The "administrative simplification" aspects of this law required the U.S. Department of Health and Human Services (DHHS) to develop standards and requirements for maintenance and transmission of health information that identifies patients.

The first of three sets of regulations, Standards for Electronic Transaction, was published on August 17, 2000 (65 FR 50312). These regulations, also referred to as the *Transactions Rule*, provide standards for eight electronic transactions and code sets to be used for the electronic transmission of certain health information. The eight HIPAA electronic transactions follow.

- Healthcare Claim or Encounter (837)
- Healthcare Claim Status (276)
- Claim Payment and Remittance Advice (835)
- Eligibility for a Health Plan (270-271)
- Referral Certification and Authorization (277)
- Enrollment/Disenrollment in a Health Plan (834)
- Premium Payments (820)
- First Report of Injury (148).

These transactions, or electronic forms, will set the standard format for patient identifiable transmissions and will use the following code sets:

- ICD-9-CM (soon to be 10)
- CPT-4
- HCPCS
- NDC

The transaction standards relate not only to reimbursement, but to human resources as well. Since the vast majority of large organizations provide health benefits to their employees, HIPAA will also impact employers outside the healthcare arena. The deadline for transaction/code set compliance is October 16, 2002.

In addition to the transaction/code set standards, there are HIPAA regulations that govern the privacy and security of patient identifiable information. This specifically applies to information that is electronic, spoken, or written. These regulations directly impact:

- Consents/Notifications/Authorizations,
- Uses and Disclosures,
- Individual Access (to the medical record) and Complaint Processes,
- Business Associate Contracts,
- Human Resource Policy,
- Workforce Training,
- Security Policies/Procedures,
- Audit Trails, and
- Communications.

The second set regulations, Standards for Privacy of Individually Identifiable Health Information, was published on December 28, 2000 (65 FR 82462). These regulations, also referred to as the *Privacy Rule*, provide standards with respect to the rights of individuals who are subjects of this information, procedures for the exercise of those rights, and the authorized and required uses and disclosures of this information. The effective date for the Privacy Rule is April 14, 2001. The Department must be in compliance by April 14, 2003.

The third set of regulations, referred to as the *Security Rule*, will consist of: (i) a rule establishing unique identifiers for employers to use in electronic health care transactions; (ii) a rule establishing unique identifiers for such transactions, and (iii) a rule establishing standards for the security of electronic information. These regulations were proposed as 63 FR 25272 and 25320 (May 7, 1998); 63 FR 32784 (June 16, 1998); and 63 FR 43242 (August 12, 1998). A final rule has not yet been published for these standards.

Still to be proposed under HIPAA are rules establishing a unique identifier for health plans for electronic transactions, standards for claims attachments, and standards for transferring among health plans appropriate standard data elements needed for coordination of benefits.

The requirements outlined by the Act and U.S. Department of Health and Human Services regulations are far-reaching. All healthcare organizations that maintain, use, or disclose healthcare information must comply. There are civil and criminal penalties for noncompliance.

All HIPAA regulations apply to organizations that capture patient identifiable electronic data, especially providers, clearinghouses, and healthcare plans. HIPAA refers to these organizations as "covered entities." In the cases where HIPAA regulations run parallel with state laws ensuring privacy and security, the more "stringent" of the two preempts the other.

The Commissioner has appointed a Chief Privacy Office and a Chief Security Officer for the Department. Each state facility has likewise appointed facility privacy and security officials who report up to the Chief Privacy and Security Officers. The Commissioner also established a Department-wide HIPAA Implementation Team in December 2000 to:

- identify new requirements HIPAA will place on the Department and its facilities;
- assess current Department systems and decide what adjustments need to be made;
- develop a workplan for making necessary adjustments;
- implement and monitor compliance consistent with an established work plan; and
- educate the Central Office, state facilities and the community on new HIPAA processes and procedures.

The Department-wide HIPAA Implementation Team has established the following workgroups to assume primary responsibility for specific areas of HIPAA implementation: Definitions; Business Associates, Contracts and Trading Partner Agreements; Transactions (Financial); Statutory and Regulatory Comparisons and Analysis; Healthcare Operations; Uses and Disclosures (General, Special Purposes, Special Classes); Consent, Authorizations, Confidentiality and Notifications; Individual Access and Complaints; Workforce and Human Resources; Training; Safeguards, Security, and Mitigation; and Questions and Answers. The team meets monthly to collectively accomplish uniform and consistent compliance across the statewide system. The Department's Risk and Liability Affairs Director coordinates this effort. Staff from the Office of the Attorney General have been assigned to work with the teams and respective workgroups throughout this process. Each state facility has a similar HIPAA team and workgroup structure.

Workgroups are responsible over the course of the next year and a half for completing work plans which are broken down into four phases with established completion deadlines:

- Assessment *Transaction & Privacy Rules* = September 28, 2001

- Design and Development — *Transaction Rule* = July 11, 2002; *Privacy Rule* = October 31, 2002
- Testing, Validation, and Justification — *Transaction Rule* = August 30, 2002; *Privacy Rule* = December 31, 2002
- Implementation — *Transaction Rule* = October 16, 2002; *Privacy Rule* = April 4, 2003.

In April 2001, the Commissioner communicated with the CSBs by memorandum advising them of the history, current status and impact of HIPAA regulations. A collaboration has been established whereby the Department has provided and will continue to provide general awareness education to the CSBs. Status reports of the Department's progress, as well as resources for implementation will also be shared with them.

New Federal Block Grant Reporting Requirements

Beginning with federal FY 2002, states will be expected to report more data to the Substance Abuse and Mental Health Services Administration (SAMHSA) for the Community Mental Health Services (CMHS) and the Substance Abuse Prevention and Treatment (SAPT) Block Grants. These data are intended to describe the performance of the state's mental health and substance abuse services systems. Initially, this reporting will be on a voluntary basis, but over time reporting of certain data sets will be required in order to receive block grant funds. From SAMHSA's perspective, performance data is required to improve planning and oversight of community-based services at the federal and state levels, and to help justify SAMHSA's budget requests. All data will be aggregated at the state level, with no individual client data requested.

The Center for Mental Health Services (CMHS) has identified "basic" and "developmental" data sets for CMHS Block Grant reporting. Referred to as the "Uniform Data Reporting System (UDRS)," these data sets are intended to answer five questions:

(1) What are the mental health service needs of the population in your state?

(2) Who in your state gets access to publicly funded mental health services?

(3) What types of services are being provided in your state?

(4) What are the consumer outcomes for the services provided?

(5) What financial resources are expended for the services?

The basic data set is to be reported on a voluntary basis beginning with federal FY 2002, but reporting will become mandatory for federal FY 2004.

The basic data set includes such information as the number of persons served by age, race, gender, ethnicity, employment status, and Medicaid status; client turnover for community-and state hospital-based services; mental health service expenditures by source of funding and service setting; and consumer perceptions of care obtained through a consumer survey.

The developmental data set includes information on the number of adult clients living independently, the number of children living in family-like settings, the characteristics of persons living in supported housing, client turnover for specific types of services (e.g., supporting housing, supported employment, and therapeutic foster care), school attendance, and criminal justice involvement. Substantial work is needed to refine the developmental data set such that it

can be reported in a consistent manner across states, and no timeframe has been established for reporting these data. The Department has applied for a grant from CMHS to assist in developing the capacity to comply with the UDRS. These "data infrastructure grants" will provide up to $100,000 per year for three years beginning October 1, 2001.

The Center for Substance Abuse Treatment (CSAT) has also identified a set of performance data that are to be reported beginning with federal FY 2002. In addition to data on the number of persons served by treatment programs that received some or all of their funding from the SAPT Block Grant, states are to report on a voluntary basis performance data that includes client change from admission to discharge regarding: 1) employment status, 2) homelessness status, 3) arrests, and 4) frequency of use of selected substances (e.g., alcohol, marijuana and cocaine).

The performance measures identified by the Center for Substance Abuse Prevention (CSAP), also to be reported on a voluntary basis beginning in federal FY 2002, are: 1) past 30-day substance use, 2) age of initiation of substance use, 3) intentions/expectations to use, 4) perception of risk/harm of substance use, and 5) attitudes about substance use. Each of these are to be assessed at the beginning and end of receiving "recurring" services from programs that receive some funding from the SAPT Block Grant.

These new reporting requirements will present significant challenges to the Department and the CSBs. Fortunately, many of these performance measures are already included in the Department's Performance and Outcome Measurement System (POMS), which will provide a solid foundation on which to build our capacity to respond to these new requirements. However, there are still many gaps in the Department's ability to address all the reporting requirements, particularly those that require data for consumers who do not meet the criteria for the Department=s priority populations (the target populations for POMS). In response to this situation, the Department is working with the VACSB Administration Committee to identify the most cost-effective strategy for collecting, managing, and reporting all Department data, including that required for the CMHS and SAPT Block Grants.

Information Technology Strategic Directions

The Department's vision for the future use of information technology is predicated on applications and strategies that improve the quality of care to Virginians, assures accountability and efficiency of the services delivery system, provides information for policy and decision-making at all levels of government, and informs the general public and interested constituents about key aspects of the services system. The principles of standardization, effectiveness, efficiency, accuracy, transportability, and user-friendliness are embedded in the strategic directions and operational strategies established for the Department's information technology program. A summary of major information technology strategic directions follows.

- *Security of Health Information* - The Department is taking necessary actions to comply with the requirements of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) related to health care information security, privacy, and data transmission. The Department must establish specific data formats and protocols for processing and transmitting data. It must meet minimum requirements for addressing the security of records and ensuring privacy of all identifiable health information. To assure data security, the Department is investigating Virtual Private Network (VPN), Public Key Infrastructure (PKI), wireless perimeter strategies, and additional security technologies. VPN will provide secure

access to the Department's network and PKI will provide the capability to sign and seal documents and facilitate secure browser access to the Department's information resources via the Internet. The integration of these technologies will increase the need to evaluate and deploy additional perimeter defenses.

- *Data Integration* - Planning is underway to integrate individual state facility patient and resident information in a data warehouse called Integrated Client Event System (ICES). This system will provide one reporting interface for multiple data allocations, thus ensuring that data are collected only once and are consistent across applications. Each application currently used by the Department to collect data outside of the Department's Patient/Resident Automated Information System (PRAIS) will be electronically linked to PRAIS.

- *Standardization* - The Department needs a wide variety of data elements pertaining to state facilities and community services in order to manage its programs, produce required reports to external funding sources and the General Assembly, and respond to inquires from the general public and other entities. Currently, the Department's data collection efforts are software and staff specific, and several data collection packages are in place at each CSB. Each software application addresses a specific data collection requirement and often that data requirement is monitored and managed by a single office in the Department. By standardizing data fields, the Department can streamline its data collection efforts and produce management reports more efficiently. To accomplish this, the Department is developing a Comprehensive Data Standards Manual that will consistently define and standardize definitions, process, output, and frequency of data to be used in CSB and state facility reporting requirements. This work is being coordinated with the Data Management Committee of the Virginia Association of Community Services Boards (VACSB). Department staff are currently working with this committee to identify all existing reporting requirements from CSBs to the Department and to develop a plan to streamline this reporting.

- *Streamlining Data Submissions* - Current reporting requirements for each CSB have increased over the years due to state and federal accountability requirements and legislative expectations. The Department, by necessity, developed multiple software applications used by the CSBs to address these reporting requirements. With new data warehousing technology and VPN technology available, the Department is in the preliminary stages of investigating the feasibility of collecting certain individual consumer data from the CSBs as a single submission to the Department. With a single submission, CSBs would submit an individual consumer data file on an established frequency. This consumer file reporting would take the place of existing reporting applications the CSBs currently use to report data to the Department. The individual consumer data from the CSBs would be warehoused in ICES, along with state facility data. Such integration through ICES has the potential to link state facility and community client data, resulting in a record of the continuum of care for individuals as they move between state facilities and community services. A single submission also would allow the Department to respond to different federal and state data submissions, including the new block grant requirements described in the preceding section.

  There are several reasons why this proposed change to CSB data reporting is being considered. First, an improvement in data quality and reliability is expected. Secondly, the reporting burden on the CSBs would be greatly reduced. Finally, efficiencies would result from automating the single file output as opposed to collecting data and keying or importing

it into the many different reporting applications. This concept is being explored in collaboration with the VACSB Data Management Committee.

State Facility Infrastructure Requirements

The Department's Office of Architectural and Engineering is responsible for planning and implementing the Capital Outlay program for the Department, the Department for the Visually Handicapped, and the Department of Rehabilitative Services. This includes responsibility for keeping the 15 state mental health and mental retardation facilities in the best possible physical plant condition within the funds appropriated to the Department. A priority of the Department is for each state facility to maintain Joint Commission on Accreditation of Health Care Organizations (JACHO) accreditation or Centers for Medicare and Medicaid Services (CMS, formerly HCFA) certification. As such, each state facility must meet requirements related to compliance with applicable Building and Life Safety Codes.

Funds for capital outlay may be appropriated from the Commonwealth's general fund, the Virginia Public Building Authority (VPBA), Treasury Loans, (when a project meets certain standards), General Obligation Bonds (when voted and approved by the general public), and Stripper Well Funds (for projects meeting strict energy savings). There are several types of capital outlay projects:

- *Maintenance Reserve.* These funds are approved by the Virginia Division of Engineering and Buildings and the Department of Planning and Budget for the repair or replacement of a plant, property or equipment. These projects generally cost between $25,000 and $500,000. Presently the Department has an approved but unfunded backlog of over $22.5 million in maintenance reserve projects, some of which have remained on this list for over 12 years.
- *Capital Outlay Projects.* These projects can be further designated as Acquisitions, New Construction, Improvements, and Equipment. Capital Outlay Project needs are submitted to the Department of Planning and Budget every odd numbered year. The Department's Capital Outlay program is linked with the Department's comprehensive planning effort, the agency's overall Comprehensive Facility Master Plan, and the individual facility Master Plans.

The Virginia Division of Engineering and Buildings requires each state facility to maintain an updated Facility Master Plan. The Department first performed this exercise in 1995 for all but one facility that had just been rebuilt. In 2001, the Department contracted with an architectural and engineering firm to revisit each facility and update the facility's Master Plan to reflect current needs and building conditions. This firm was to research the manner in which each state facility had followed its original Master Plan and to propose appropriate state facility building uses over the next six years.

The average age of buildings across the state mental health and mental retardation facilities is over 50 years old. Many of these buildings were originally built for custodial care of facility patients and residents and do not conform to today's standards for the treatment and habilitation services. Nor would they meet present Life Safety and Building Codes. For example, the Department still has several facilities that have not been sprinkled for fire prevention. Many existing state facility buildings must undergo major renovations or must be rebuilt to respond to current and future service needs. As funds are appropriated, the Department tries to renovate or replace buildings to assure compliance with most recent Codes, provide efficient heating ventilation and air conditioning, eliminate pony (or half-walls) walls, address privacy issues, and

comply with Americans with Disabilities Act (ADA) requirements.

Projects that cover the same needs at many state facility buildings across the Department are known as "umbrella" projects. These include resolution of life safety issues; environmental issues; demolition of unsafe buildings; and boilers, steam lines, and air conditioning issues.

In planning for the Department's six year capital program in 1996, the Department's total was $390,000,000. This equated to:

- $306,000,000 for Mental Health Facilities, Maintenance Reserve, and Umbrella Projects; and
- $83,000,000 for the Mental Retardation Training Centers.

In planning the 2002-2008 capital outlay program, even with the past six years of inflation, the Department's capital resource requirements totaled $205,800,000. This equates to:

- $28,000,000 Maintenance Reserve,
- $62,000,000 Umbrella Projects,
- $49,300,000 Mental Health Facilities, and
- $66,500,000 Mental Retardation Training Centers.

The $185,000,000 reduction in the Department's six year capital outlay program plan is in large part the product of six years of careful planning to concentrate capital fund requests on those buildings that will carry the Department's plans for ten or more years into the future. A summary of some of the major capital planning issues and facility proposals included in the Department's 2002-2008 Capital Outlay Plan follow.

- ***Eastern State Hospital*** - Due to the original type of construction, the present buildings that house the geriatric population do not allow for the required patient privacy. This lack of privacy has been cited by CMS. Additionally, there are issues around compliance with ADA requirements, and the heating ventilation and air conditioning systems do not function properly. To correct these issues, it would be more economical to renovate the presently empty buildings 28, 29, and 30, which are within the main campus complex. Upon completion of these required renovations, the entire geriatric population would be relocated to the main part of the campus. Other structural problems at this facility also must be addressed.
- ***Western State Hospital*** - This facility is located on a sprawling campus with many empty structures. Potentially, a new program of treatment for civilly committed sexually violent predators may be placed on this site. This 30 bed two-ward specialized treatment program would require a secure setting. To make room for this program, five currently empty buildings would have to be extensively renovated for use by the hospital's patient population.
- ***Southeastern Virginia Training Center*** - Currently, the residential living areas at this facility could not withstand minimum category one hurricane force winds. The original cottages were built in 1975 to house, treat, and train ambulatory residents with moderate retardation. Current training center residents have severe retardation and many have physically handicapping conditions that require special wheelchairs and medical apparatus. Three new structures are proposed to provide additional room required to care for the center's nonambulatory residents. These building would be designed and constructed of materials capable of withstanding a category three hurricane should that be necessary.

- ***Northern Virginia Training Center*** - Although the training center has made remarkable advances in staffing and innovative treatment programs, its residential living units have not been changed since they were constructed over thirty years ago. Originally, the training center was designed to serve ambulatory residents with moderate retardation. The current population has severe retardation and physically handicapping conditions. The Department is proposing renovations and an addition to building 4, renovations to building 1, and renovations to the cottages to increase available space for medical storage, achieve compliance with current ADA standards for bathrooms and doorways, and make other building improvements that will enhance the quality of life for residents.
- ***Southside Virginia Training Center*** - This training center is divided by U.S. Route 1, which creates two separate north and south campuses. While most of the structures on the north campus are empty, the existing multipurpose building is used for many activities and training. This requires transporting residents across U.S. Route 1 for activities and training. The Department is proposing a project to construct a new patient activity building near the present living cottages on the south campus, thereby eliminating the present need for the north campus and creating a safer environment for both residents and staff. Declaring this north campus property surplus would result in an immediate savings in energy to this campus and its potential sale would provide funds for Department's Trust Fund.

  Another prominent need at this facility is to consolidate all existing physical plant structures, now housed in various older buildings, under one roof. This will, for the first time, allow vehicle repairs to be made under a roof and out of the weather. This structure is expected to increase the efficiency of the Southside Complex's physical plant staff.
- ***Central Virginia Training Center*** - This facility has experienced significant census reductions in recent years. In consultation with outside architects and engineers, the Department has designated "core buildings" for future service and living areas. These buildings are in close proximity to each other. All capital renovations would be concentrated on these buildings, which are structurally sound but in need of interior modifications such as sprinklers, upgraded heating and air conditioning, resolution of environmental and energy issues, and modification of bathrooms to meet ADA requirements. The Department is proposing the phased renovation of eleven structures to comply with present Life Safety and Building Code requirements.
- ***Central State Hospital*** - This facility houses the State's maximum security forensic unit. Additionally, the hospital serves individuals who are not guilty by reason of insanity (NGRI). The Department is proposing staged renovations of buildings 93, 94, and 95, to provide the necessary security for these patients. Additionally, building 113, which houses the hospital's administrative offices, is no longer structurally sound, has climate control problems, and is insufficient in size. An existing structure, building 43, located adjacent to buildings 39, 93, 94, 95, and 96, is structurally sound and readily adaptable for administration space.
- ***Southwestern Virginia Training Center*** - As with the other training centers built in 1975, this facility was constructed to train ambulatory individuals with moderate mental retardation for an active life in the community. Current residents have severe retardation and many have physically handicapping conditions. The Department is proposing to renovate the cottages to allow for larger day rooms, much needed storage space, and modifications to the bathrooms to meet ADA requirements.

- ***Southwestern Virginia Mental Health Institute*** - To consolidate all patient activities under one roof and meet new treatment needs, the Department proposes to modify three existing structures, which are presently connected by a climate controlled pedestrian walkways, into a treatment mall, renovate the food service area, and add much needed administrative areas. These improvements will complete this facility's efforts to meet today's standards for mental health inpatient treatment.
- ***Northern Virginia Mental Health Institute*** - This facility was recently renovated and enlarged to provide updated active treatment services and additional patient beds. These improvements resulted in a dire need for patient programming space, staff parking space, and administrative offices. The Department is proposing planning money to design a parking deck with administrative offices on the grade level. By moving the institute's administrative offices, a large area of the original building would be available for renovation into a treatment mall for programming and patient activities.

With the exception of approved but unappropriated maintenance reserve projects, facilities that have no major capital outlay plans include:

- Commonwealth Center for Children and Adolescents,
- Catawba Hospital,
- Hiram Davis Medical Center,
- Piedmont Geriatric Hospital, and
- Southern Virginia Mental Health Institute.

In the late 1980s, a Governor's directive instructed each agency and each state facility to work on an energy program to reduce its energy consumed. This directive has been reissued by each succeeding governor. The Department has been very resourceful in its efforts to fund the projects that have resulted in energy reductions and received several awards for its initiative and efforts to meet and exceed this directive. Most of the Department energy saving projects were initially funded by the state general funds as capital outlay projects, either through maintenance reserve or individual capital outlay projects. Some projects were funded by Treasury Department Loans, paid back with energy savings. Other funds were received from Stripper Well Rebates from the Department of Mines Minerals and Energy. Projects have been initiated in the following areas:

- New Motors
- Boiler Replacements
- Steam Line Repair
- Trap Maintenance Plan
- Ice Storage
- Steam Pressure Reduction
- Closing Buildings
- New Generators
- Window and Door Replacements
- Gas Brokerage
- Frozen Rate for Electrical Contract
- Electrical Metering and Real Time Monitoring
- Re-lamping
- Chiller Replacement
- Duct Cleaning and Insulation
- Window Air-Conditioning
- Reinsulation of Piping
- Replacement of Refrigeration Equipment
- Replacement of Trucks with Golf Carts
- Cooling Tower Replacement
- Ozone Laundries
- Energy Maintenance Management Systems
- Roof Insulation
- Commissioning Heating/Air Conditioning Projects

- PACRAT Software Energy Management System Evaluation
- MP-2 Computerized Maintenance Management System

There are no measurable ways to calculate the total savings that this Department has realized through its efforts to meet the Governor's Directive. If the various methods used by the Department were to be calculated, it is likely the agency has exceeded these energy directive requirements. The Department's proposed capital projects and a summary of the various energy saving projects implemented by the Department are provided in Appendix G.

Goals, Objectives, and Strategies

Goal: Improve the ability of the Department, state facilities, and CSBs to manage information efficiently in an environment that is responsive to the needs of users and protects identifiable health information for individuals receiving publicly-funded mental health, mental retardation, and substance abuse services.

Objectives:

1. Implement the Department Information Technology Strategic Plan.

Strategies:

a. Develop and implement a Comprehensive Data Standards Manual that consistently defines data elements, processes, and outputs in FY 2003.

b. Complete development of management information systems identified in the Information Technology Strategic Plan.

c. Explore opportunities to realize data management efficiencies.

d. Continue to improve the Department's web site and electronic communication capabilities.

2. Expand the capacity of the Department to use warehousing technology to integrate information from different automated systems.

Strategies:

a. Take steps to integrate individual consumer information through the Integrated Client Event System (ICES) during FY 2003.

b. Investigate, in collaboration with CSBs, the feasibility of collecting certain individual client information through a single submission to the Central Office in order to meet federal block grant and state reporting requirements during FY 2003 and make a recommendation to the Commissioner on the feasibility in FY 2004.

3. Successfully implement HIPAA regulatory requirements at the Central Office and state facility levels within required time frames.

Strategies:

a. Direct and monitor the work of the Department-wide HIPAA Implementation Team and individual state facility HIPAA Implementation Teams through the assessment; design and development; testing, validation, and justification; and implementation phases.

b. Share information with CSBs regarding HIPAA requirements and the Department's progress in achieving HIPAA compliance.

c. Seek resources required to implement HIPAA requirements as part of the agency's biennial budget submissions.

Goal: Assure that the capital infrastructure of state mental health and mental retardation facilities are safe, appropriate for the provision of current service methods, and efficient to operate.

Objectives:

1. Improve the capital infrastructure of state mental health and mental retardation facilities to assure their compliance with life safety and applicable building codes and their appropriateness for active treatment and habilitation services.

Strategies:

a. Seek resources to address individual state facility capital outlay needs identified in the Department's Six Year Capital Outlay plan.

b. Continue to update individual state mental health and mental retardation facility master plans to respond to programming needs of patients and residents.

V. Resource Requirements

RESPONSES TO CRITICAL ISSUES FACING THE SERVICES SYSTEM

The Department has identified responses to the critical issues facing Virginia's services system. These responses focus on:

- Enhancing staffing levels in the mental retardation training centers to meet expectations established under the Civil Rights for Institutionalized Persons Act (CRIPA);
- Expanding and enhancing existing discharge assistance and diversion projects that support individualized community alternatives for state mental health facility patients who are clinically ready for discharge and training center residents who have chosen community services and supports;
- Reducing CSB waiting lists for specific community services for:
  - children and adolescents with serious emotional disturbances and adults with serious mental illnesses,
  - adolescents and adults with substance dependence or abuse; and
  - individuals with mental retardation who are not eligible for Medicaid MR Waiver services and start-up funds for MR Waiver slots.
- Expanding targeted community-based services, including comprehensive case management services, psychiatric services, PACT teams, prevention services, and second generation anti-psychotic medications;
- Replicating the Northern Virginia Training Center Regional Community Support Center Project (Center for Excellence) at the four other training centers to provide CSBs specialized medical, dental, behavioral consultation, psychiatric, and other clinical services that are not available in the community;
- Implementing regional initiatives in Eastern and Southern Virginia to develop and expand community services aimed at keeping individuals in the community and stabilizing or reducing demand for hospitalization in state mental health facilities;
- Implementing regional initiatives in Central Virginia and the Charlottesville areas to develop new community-based crisis stabilization models;
- Implementing targeted mental health and substance abuse jail services for adults in local and regional jails and youth in juvenile detention facilities to divert state facility admissions;
- Achieving internal human rights system and licensing system improvements;
- Achieving compliance with the federal Health Insurance Portability and Accountability Act;
- Implementing a Sexually Violent Predators Program to provide specialized treatment to civilly-committed sex offenders;
- Addressing increased energy costs at the state mental health and mental retardation facilities;
- Maintaining the new financial management information system, FMS II;

- Addressing a shortfall in state general fund match for projected Medicaid collections in state facilities and an existing budget shortfall at Eastern State Hospital.

A summary of each needed response follows.

Enhance MR Training Center Staffing

The Department needs $9,467,697 ($4,609,696 in state general funds and $4,858,001 in non-general funds) in FY 2003 and $14,215,763 ($6,921,467 in state general funds and $7,294,296 in non-general funds) in FY 2004 to incrementally move the four training centers listed in the table below towards the staffing expectations established under the Civil Rights of Institutionalized Persons Act (CRIPA). Additional improvements in the staff-to-resident ratios are expected at the two large training centers, CVTC and SVTC, as they discharge residents who choose community services. Following an initial investigation by the U.S. Department of Justice (DOJ) in 1990, the Northern Virginia Training Center successfully implemented its plan of improvement. This plan required:

- increased facility professional staff (psychologists, physicians, nurses, and occupational therapists) and enhanced staff training;
- increased focus on individualized active treatment and habilitation;
- provision of community placements for residents who choose community services; and
- increased efforts to protect resident rights, safety, and well-being.

The remaining training centers now must be brought up to the individualized services planning, active treatment and habilitation, professionally recognized best clinical practices, and staffing levels provided for in the Department's DOJ settlement agreements.

Training Center	FY 2003		FY 2004	
	GF	NGF	GF	NGF
Central Virginia Training Center (CVTC)	1,196,814	1,264,753	1,797,018	1,899,029
Southeastern Virginia Training Center (SEVTC)	1,298,251	1,353,406	1,949,326	2,032,141
Southside Virginia Training Center (SVTC)	877,360	939,121	1,317,358	1,410,091
Southwestern Virginia Training Center (SWVTC)	1,237,271	1,300,721	1,857,765	1,953,035
Total	4,609,696	4,858,001	6,921,467	7,294,296

Discharge 70 State MH Facility Patients to Appropriate Community Services

The Department needs $4,956,000 in state general funds in FY 2003 and $4,956,000 in state general funds in FY 2004 to reduce the census of state mental health facilities by discharging 70 long-term patients to appropriate community services. These individuals have specific, multiple needs that have previously prevented their discharge to the community. To address these needs, individualized services plans, projected to have an average cost of $70,000 per year, would be developed and implemented for each individual. In addition, the Department would establish one position to conduct utilization review and monitoring functions. This initiative would expand the Department's Discharge Assistance Project (DAP) which is currently supporting community placements for over 325 former long-term patients. Since their DAP enrollment, these individuals have experienced low state hospital readmissions and a 90 percent decline in total bed days used.

Discharge 100 MR Training Center Residents Requesting Community Services

The Department needs $7,248,980 ($3,552,000 in state general funds and $3,696,980 in non-general funds) in FY 2003 and $7,248,980 ($3,552,000 in state general funds and $3,696,980 in non-general funds) in FY 2004 in the DMAS budget to develop community-based services for 100 training center residents who have chosen community services rather than continued training center placements. This initiative would provide federal Medicaid and state general fund match in the Department of Medical Assistance Services budget for MR Waiver services and supports. Community placements would be initiated through individualized plans of care developed by the CSBs and preauthorized by the Department. The annual cost of state training center placement is projected to be $108,920 by 2003. The average MR Waiver costs for persons discharged from training centers is projected to be $72,532, or $35,520 in state general funds.

Enhance Funding for the Region IV Acute Care Project

The Department needs $500,000 in state general funds in FY 2003 and $500,000 in state general funds in FY 2004 to offset increased costs for local hospital bed purchases under the project. The Region IV Acute Care Project uses local hospital beds as an alternative to acute hospitalization at Central State Hospital. To date, this project has served over 750 patients in local hospitals, with an average length of stay of 5.5 days. Local hospitals participating in this project have contracts that are renewable annually for five years. Each year, these hospitals can increase their per diem and physician charges, if any, up to the Consumer Price Index (CPI) for that year. There are three renewable one-year periods remaining on the existing contract.

Enhance Funding for the Northern Virginia Discharge and Diversion (DAD) Project

The Department needs $105,545 in state general funds in FY 2003 and $216,050 in state general funds in FY 2004 to offset increased costs for local hospital bed purchases under the project. The DAD Project provides a local alternative to acute care provided at the Northern Virginia Mental Health Institute. In addition to offsetting the annual CPI adjustment for local bed purchases, this initiative would add $50,000 to base funding to accommodate population growth in the area. The DAD project relies on local bed purchases for patients who require acute hospitalization for less than ten days and provides an alternative to the Institute if its beds are not available. This project has been successful in enabling the Institute to meet staffing and DOJ requirements. It has served over 421 individuals.

Provide Community Mental Health Services to Children, Adolescents, and Adults on CSB Waiting Lists

The Department needs $6,487,693 ($4,727,000 in state general funds and $1,760,693 in non-general funds, including anticipated Medicaid and third party payer fees, direct client fees, and other revenues) in FY 2003 and $12,975,386 ($9,454,000 in state general funds and $3,521,386 in non-general funds) in FY 2004 to provide an expanded array of community mental health services (excluding adult counseling and psychotherapy, case management, assertive community treatment and psychiatric services) for children, adolescents, and adults on CSB waiting lists as of April 2, 2001. This represents the first phase of a four year process of addressing documented needs of individuals on CSB waiting lists. Community mental health services and supports promote risk reduction, family health, and stability; provide timely interventions and appropriate treatment; restore and maintain functional skills; support stable living arrangements; and encourage recovery, personal growth, and increase capacity for self-responsibility. To

fully respond to these documented community mental health service needs, $14,181,000 in state general funds and $5,282,079 in non-general funds would be needed in FY 2005 and $18,908,000 in state general funds and $7,042,772 in non-general funds would be needed in FY 2006.

Provide Community Substance Abuse Services to Adolescents and Adults on CSB Waiting Lists

The Department needs $2,153,040 ($1,872,450 in state general funds and $280,590 in non-general funds, including anticipated Medicaid and third party payer fees, direct client fees, and other revenues) in FY 2003 and $4,306,080 ($3,744,900 in state general funds and $561,180 in non-general funds) in FY 2004 to provide an expanded array of community substance abuse services (excluding case management, assertive community treatment and psychiatric services) for adolescents and adults on CSB waiting lists as of April 2, 2001. This represents the first phase of a four year process of addressing documented needs of individuals on CSB waiting lists. Untreated substance addiction has a direct impact on productivity, public safety, and family stability. Treatment for addiction results in significant reductions in substance abuse and in a significant reduction in criminal involvement. Treatment also is associated with improvements in the mental and physical health of individuals receiving services. To fully respond to these documented community substance abuse service needs, $5,617,350 in state general funds and $841,770 in non-general funds would be needed in FY 2005 and $7,489,000 in state general funds and $1,122,360 in non-general funds would be needed in FY 2006.

Develop a Secure Primary Substance Abuse Diversion Program

The Department needs $1,000,000 in state general funds in FY 2003 and $560,000 in state general funds in FY 2004 to establish one specialized residential program of approximately six to eight beds to serve an estimated 200 individuals annually at a cost of approximately $4,000 per individual ($400 per day 10 days average stay). These individuals require substance abuse services and meet commitment criteria according to the *Code of Virginia* but do not require intensity of treatment provided in a state mental health facility. The current SA diversion projects have used local bed purchases, conversion of existing programs to accommodate temporary detention orders, and partnering with private providers. These approaches do not provide the level of security envisioned for this proposed program. In FY 2003, approximately $750,000 would be required for start-up costs, including facility renovations, furnishings, equipment, supplies and staff recruitment and training. Once this program is operational, approximately 30 percent of the operating budget could be recovered through existing funding streams such as TDO reimbursements and the Department=s substance abuse residential purchase program (SARPOS).

Provide Community Mental Retardation Services to Individuals Who Are Not Eligible for the Medicaid MR Home and Community-Based Waiver (MR Waiver)

The Department needs $4,874,584 ($3,617,675 in state general funds and $1,256,909 in non-general funds, including anticipated Medicaid and third party payer fees, direct client fees, and other revenues) in FY 2003 and $9,749,168 ($7,235,350 in state general funds and$2,513,818 in non-general funds) in FY 2004 to provide community mental retardation services (excluding case management and psychiatric services) for individuals on CSB waiting lists as of April 2, 2001 who are not eligible for MR Waiver services. This represents the first phase of a four year process of addressing documented needs of individuals on CSB waiting lists. To fully respond to these documented community mental retardation service needs, $10,853,025 in state general funds and $3,770,727 in non-general funds would be needed

in FY 2005 and $14,470,700 in state general funds and $5,027,636 in non-general funds would be needed in FY 2006.

Provide Start-Up Funds for MR Waiver Services

The Department needs $800,000 in state general funds in FY 2003 and $600,000 in state general funds in FY 2004 to fund MR Waiver provider start-up costs that are not covered by Medicaid. These costs include renovations for special accessibility needs of consumers; furniture; clothing, household goods, and personal items for individuals leaving state training centers, and staff training time for new employees. Of the over 5,000 individuals approved to receive MR Waiver services, more than 400 have not been able to receive services because of the lack of providers or the inability of existing providers to have trained staff. This funding would provide one-time funding, averaging $2,000 per individual, for start-up costs for 400 individuals in FY 2003 and 300 individuals in FY 2004 who would otherwise be unable to access MR Waiver services from public and private mental retardation services providers.

Provide Mental Health, Mental Retardation, and Substance Abuse Case Management Services

The Department needs $1,517,653 ($1,175,461 in state general funds and $342,192 in non-general funds, including anticipated Medicaid and third party payer fees, direct client fees, and other revenues) in FY 2003 and $2,999,306 ($2,350,922 in state general funds and $648,384 in non-general funds) in FY 2004 to enable CSBs to expand comprehensive mental health, mental retardation, and substance abuse services for individuals identified by CSBs as waiting for this service on April 2, 2001. This represents the first phase of a four year process of addressing documented needs of individuals on CSB waiting lists. Funding needed is based on a case ratio of 35 consumers per additional FTE case manager. To fully respond to current documented case management service needs, $3,526,384 in state general funds and $1,026,576 in non-general funds would be needed in FY 2005 and $4,601,845 in state general funds and $1,368,768 in non-general funds would be needed in FY 2006.

Expand Community Psychiatric Services

The Department needs $1,800,000 ($1,500,000 in state general funds and $300,000 in non-general funds, including anticipated Medicaid and third party payer fees, direct client fees, and other revenues) in state general funds in FY 2003 and $1,800,000 ($1,500,000 in state general funds and $300,000 in non-general funds) in state general funds in FY 2004 to hire ten FTE psychiatrists in geographic areas with critical shortages in psychiatric services. Psychiatric services provided by these psychiatrists would divert a significant number of individuals from inpatient care, enabling them to remain in the community while receiving closely monitored medications and other psychiatric services. CSBs indicate their ratios of psychiatrists to enrolled patients are far in excess of acceptable ranges. Reasonable caseloads for their populations vary from 300 to 500 consumers per psychiatrist, depending upon the availability of other resources, local conditions, and consumer risk factors. In some areas, current ratios are much higher, from 800 to 1,500 consumers per psychiatrist.

Add Two New Programs of Assertive Community Treatment (PACT) Teams

The Department needs $1,400,000 in FY 2003 and $1,400,000 in state general funds in FY 2004 to expand Virginia's PACT initiative by funding two new teams in Portsmouth and Mt. Rogers CSBs. When fully operational, these teams are projected to serve 160 consumers with serious mental illness who have

long or frequent inpatient stays in state mental health facilities. The goal is to reduce the level of state hospitalization among these individuals by approximately 80 percent by the end of the biennium.

Establish Prevention Programs for High-Risk Youth and Families

The Department needs $1,500,000 in state general funds in FY 2003 and $1,500,000 in state general funds in FY 2004 to enable 15 CSBs, through a competitive grant process, to develop science-based indicated prevention programs that will target individuals who are:

- exhibiting early signs of substance abuse or other problem behaviors associated with substance abuse, but have not reached the point of clinical diagnosis of substance abuse, or
- exhibiting specific risk factors such as early substance use, school failure, interpersonal social problems, delinquency and other anti-social behaviors, and psychological problems.

Expand Access to Atypical Medications in CSBs

The Department needs $3,700,000 in state general funds in FY 2003 and $3,700,000 in state general funds in FY 2004 to expand the availability of second-generation anti-psychotic medications in CSBs. Demand for these medications has increased incrementally, resulting in a $660,000 deficit in this item in FY 2001. These medications are critically important as they provide symptom reduction and remission of illness for individuals with severe mental illnesses and decrease the need for state hospital admissions.

Replicate the Northern Virginia Training Center's Regional Community Support Center (Center for Excellence) at All Training Centers

The Department needs $1,800,000 in state general funds in FY 2003 and $1,400,000 in state general funds in FY 2004 to enable four additional training centers to secure and offer individuals receiving community mental retardation services specialized medical, dental, behavioral consultation, psychiatric, and other clinical services that are not readily available in their communities. In addition to these specialized services, this project would allow these centers to provide professional training and education opportunities to community staff. Approximately 400 individuals are projected to be served with this funding. In FY 2003, each of the four training centers will need $100,000 in one-time funds for initial capital improvements.

Implement the Southern Virginia Regional Initiative to Develop Community Capacity

The Department needs $6,010,000 in state general funds in FY 2003 and $4,625,000 in state general funds in FY 2004 to develop and expand a network of community-based services in the three CSBs (Danville-Pittsylvania, Piedmont, and Southside CSBs) served by the Southern Virginia Mental Health Institute (SVMHI). These services would include crisis stabilization, local hospital acute psychiatric bed purchases, establishment of a PACT team in Danville-Pittsylvania CSB and Intensive Community Treatment teams in Piedmont and Southside CSBs, and housing and residential services. These CSBs suggest that this initiative would reduce SVMHI admissions by 50 percent and eliminate the existing practice of diverting individuals in crisis from the area to other state mental health facilities such as Western State Hospital and Catawba Hospital. In FY 2003, $1,385,000 in one-time start-up funds would be needed to acquire housing for three group homes and ten apartments.

Implement the Eastern Virginia Regional Initiative to Develop Community Capacity

The Department needs $9,528,752 ($8,299,302 in state general funds and $1,299,270 in anticipated non-general funds, including Medicaid and third party payer fees, direct client fees, and other revenues) in FY 2003 and $9,528,752 ($8,299,302 in state general funds and $1,299,270 in non-general funds) in FY 2004 to implement a regionally-developed plan for an effective system of community-based services and supports for individuals with serious mental illness. This plan is intended to minimize reliance upon Eastern State Hospital and expand capacity for community care throughout the region, thereby enhancing the safety and well-being of persons receiving services. Current demand for community services exceeds existing CSB capacity and individuals receiving long-term care at Eastern State Hospital have few options for community placement. Significant reductions in the ability of CSBs to access acute psychiatric care locally have increased demand for hospitalization at Eastern State Hospital. This initiative would develop or expand a range of community-based crisis stabilization, acute inpatient bed purchase, case management, assertive community treatment, day treatment/partial hospitalization, psychiatric/nursing time, residential, discharge planning, and community support services, as specifically identified by each CSB. Additionally, the plan calls for the establishment of a regional acute care bed purchase arrangement similar to that employed by the Region IV Acute Care Project. The CSBs estimate that services proposed through this plan would be provided to 3,655 individuals.

Implement Regional Crisis Stabilization Programs in Region IV (Central Virginia) and Region I (Northwestern Virginia)

The Department needs $1,443,174 in state general funds in FY 2003 ($721,587 for each program) and $1,111,200 in state general funds in FY 2004 ($555,600 for each program) to create two regional eight-bed community-based crisis stabilization programs to serve the Central Virginia and Northwestern Virginia regions. These programs would accept admissions 24 hours per day, 365 days per year. Individuals would stay from one to five days, with utilization review and approval required for any individual continuing beyond the fifth day. Services would include room and board, psychiatric services, daily nursing services, daily medication/pharmacological services, individual and group problem resolution counseling, intensive case management to address benefit eligibility and housing needs, symptom and behavior management, treatment coordination, and discharge planning. This program would serve adults who do not require the structure or services of an acute inpatient facility. With a per diem rate of $490, it would provide greater choice and a more clinically appropriate and cost-effective treatment option for many consumers. The Region IV CSBs recognize that many adult consumers who are now being referred to acute inpatient settings could be treated in a less-intensive and less-restrictive residential setting. A setting of this type does not currently exist in that region. This is also the case in Region I. The Central Virginia program would be managed by the Richmond Behavioral Healthcare Authority for the Region IV CSBs. The Northwest Virginia program would be managed by the Region Ten CSB for the Region I CSBs. Each of these proposals includes $58,000 in one-time start-up funds in FY 2003. Each program projects Medicaid revenues of $77,133 in FY 2003 and $185,120 in FY 2004 for crisis stabilization services.

Provide Targeted Mental Health and Substance Abuse Services in Jails and Juvenile Detention Centers

The Department needs $1,471,832 in state general funds in FY 2003 and $1,471,832 in state general

funds in FY 2004 to provide CSB mental health and substance abuse case management and medication management services in local and regional jails and juvenile detention centers. CSBs surveyed for a six-month period from November 1, 2000 to April 30, 2001 estimated that approximately 4,092 adult and 1,056 youth offenders needed some type of mental health service and 6,124 adult and 1,609 youth offenders needed some type of substance abuse service.

This CSB jail survey data represented 70 percent of jails and 77 percent of juvenile detention centers. Extrapolating this data statewide, the Department estimates that:

- 4,747 adult and 1,267 youth offenders need some type of mental health service; and
- 7,104 adult and 1,931 youth offenders need some type of substance abuse service.

The Department applied existing unit costs to the CSB-identified needed service units to estimate $18,629,599 would be required to address all identified needs across all services during the six-month survey period. The requested funds would focus only on case management and medication management services and would provide:

- Mental health case management services to 1,899 adults and 276 youth offenders and medication management services to 697 adults and 212 youth offenders; and
- Substance abuse case management services to 2,438 adults and 374 youth offenders and medication management services to 119 adults and 16 youth offenders.

Create a Secure Juvenile Mental Health Treatment Program

The Department needs $6,903,952 in state general funds in FY 2003 and $1,840,051 in state general funds in FY 2004 to create a secure juvenile mental health treatment program. During the first eight months of 2001, 31 percent (86 admissions) to the Commonwealth Center for Children and Adolescents (CCCA) were forensic juvenile admissions. These admissions used 2,283 bed days, or 26 percent of all CCCA bed days. Last year, the General Assembly considered legislation to codify the insanity defense in juvenile court proceedings. Such action, if passed, would likely result in increased numbers of juveniles admitted to state facilities who are at risk of harming others and who require treatment in a more secure setting than is currently possible at CCCA. To address the needs of this population, which presents serious public safety concerns, funding would be needed to convert an existing adolescent unit (or pod) at CCCA to a ten bed unit with secure status and to add a new twelve bed secure pod adjacent to the newly converted pod. This new pod would include space for in-unit dining, recreational and school for juveniles treated in the two secure units. To support this new program, additional security and clinical staff would be required. One-time costs of $900,250 would be required for the pod conversion and $6,903,952 for the construction of a new pod.

Increase the Number of Department Human Rights Advocates

The Department needs $340,000 in state general funds in FY 2003 and $680,000 in state general funds in FY 2004 to hire five new human rights compliance auditors in FY 2003 and five additional human rights advocates in FY 2004. Currently, 25 advocates provide comprehensive advocacy services to over 200,000 individuals receiving services from the fifteen state mental health and mental retardation facilities and 450 provider organizations in Virginia. The work load of these advocates, particularly the regional advocates who already maintain very high caseloads and cover large geographic areas, is expected to increase with the new human rights regulations now in effect.

Increase the Number of Department Licensing Specialists

The Department needs $245,450 in state general funds in FY 2003 and $245,450 in state general funds in FY 2004 to hire four additional licensing specialists, bringing the total number of licensing specialists to 16. These specialists are needed to monitor regulatory compliance by community providers of mental health, mental retardation, and substance abuse services and to license the new services covered by the revised licensing regulation. Licensing regulations currently cover over 450 provider organizations that operate 1,000 services. One-time equipment costs are included in this proposal.

Achieve Compliance with the Health Insurance Portability and Accountability Act (HIPAA)

The Department needs $3,410,004 in state general funds in FY 2003 and $1,288,004 in state general funds in FY 2004 to enable the Department and each state mental health and mental retardation facility to take necessary steps to comply with HIPAA regulatory requirements. The regulations specifically target protected health information (PHI) that is patient identifiable. Compliance must be met for the transaction standards by October 2002. Compliance for the security and privacy regulations must be fully implemented by April 2003. Major actions include:

- Software modifications to transaction processing programs, including billing, payments and adjustments, and benefit enrollment;
- Software modifications that report minimally necessary protected health information;
- Development of a secure email network that encrypts all email and attachments within a public key infrastructure (PKI);
- Development of software that tracks changes to records, monitors access controls, and records complaints;
- Reengineering of business processes that involve consents, authorizations, disclosures, uses, and notifications;
- Assessment of Department and state facility risk management that fully analyzes the legal implications of HIPAA compliance; and
- Improved physical security of buildings, wards, and offices throughout the 15 facilities and Central Office.

This proposal includes $2,122,000 in one-time start-up funding in FY 2003.

Implement a Sexually Violent Predators Program

The Department needs $9,945,149 in state general funds in FY 2003 and $4,899,049 in state general funds in FY 2004 to establish a Sexually Violent Predators Program that with provide specialized treatment for individuals who have been civilly committed to the program pursuant to §37.1-70.1 through §37.1-70.19 of the *Code of Virginia*. These funds would support a 30 bed, two ward specialized treatment program; a Department office to coordinate the assessment of persons with sexually deviant disorders and serve as liaison with the Office of the Attorney General and the Department of Corrections; and a university-affiliated research project to evaluate the efficacy of the assessment and treatment programs. In FY 2003, $5,046,100 in one-time funds would be required for capital and security requirements, furnishings, and equipment.

Address Increased State Facility Energy Costs

The Department needs $2,000,000 in state general funds in FY 2003 and $2,000,000 in state general

funds in FY 2004 to cover the increased energy-related expenses experienced by state mental health and mental retardation facilities during the past 18 months. These funds would be used to offset costs of fuel oil, natural gas, and electricity. Proper lighting and temperature levels are essential environmental conditions that contribute to effective service delivery. Currently, state facilities are using funds budgeted for other supply and maintenance items and personal services to cover these increased costs. Continuation of this practice will result in delays in preventive maintenance, insufficient inventory levels of essential supplies and repair materials, and delays in refilling vacant positions. This increases the risk to facility patients and residents.

Fund Phase Two FMS II Implementation

The Department needs $217,375 in state general funds in FY 2003 and $161,775 in state general funds in FY 2004 to complete the implementation of an updated financial management system, FMS II, and to provide for ongoing maintenance costs.

Address General Fund Medicaid Match Shortfall

The Department needs $13,700,000 in state general funds in FY 2003 and $13,700,000 in state general funds in FY 2004 to provide match for projected Medicaid collections in state facilities. The addition of these general fund match amounts to the Department of Medical Assistance Budget will enable the Department to collect projected Medicaid revenue in FY 2003, FY 2004, and the years thereafter.

Address Existing Budget Shortfall at Eastern State Hospital

The Department needs $1,200,000 in state general funds in FY 2003 and $1,200,000 in state general funds in FY 2004 to increase the base appropriation of Eastern State Hospital. During the development of the 1996-1998 biennium budget, the hospital's base appropriation was reduced due to a declining census. However, after a Department of Justice review, it was determined that staffing levels were not sufficient.

The following table summarizes 2002-2004 biennium resource requirements identified by the Department:

Proposed Initiative or Request	**FY 2003** SGF	NGF	**FY 2004** SGF	NGF	**Biennium Total** SGF	NGF
Enhance MR Training Center Staffing	4,609,696	4,858,001	6,921,467	7294,296	11,531,163	1,215,297
Discharge 70 State MH Facility Patients	4,956,000		4,956,000		9,912,000	
Discharge 100 MR Training Center Residents*	3,552,000	3,696,980	3,552,000	3,696,980	7,104,000	7,393,960
Enhance Region IV Acute Care Project	500,000		500,000		1,000,000	
Enhance DAD Project	105,545		216,050		321,595	
Fund Community MH Services to Address CSB Waiting Lists	4,727,000	1,760,693**	9,454,000	3,521,386**	14,181,000	5,282,079**

Proposed Initiative or Request	FY 2003		FY 2004		Biennium Total	
	SGF	NGF	SGF	NGF	SGF	NGF
Fund Community SA Services to Address CSB Waiting Lists	1,872,450	280,590**	3,744,900	651,180**	5,617,350	841,770**
Develop a Secure Primary SA Diversion Program	1,000,000		560,000		1,560,000	
Fund Community MR Services For Non-Waiver Eligible Individuals on CSB Waiting Lists	3,617,675	1,256,909	7,235,350	2,513,818	10,853,025	3,770,727
Provide Start-Up Funds for MR Waiver Services	800,000		600,000		1,400,000	
Provide MH, MR, and SA Case Management Services	1,175,461	342,192**	2,350,922	648,384**	3,526,383	990,576**
Expand Community Psychiatric Services	1,500,000	300,000**	1,500,000	300,000**	3,000,000	600,000**
Add Two PACT Teams	1,400,000		1,400,000		2,800,000	
Establish Prevention Programs	1,500,000		1,500,000		3,000,000	
Expand Access in CSB to Atypical Medications	3,700,000		3,700,000		7,400,000	
Replicate NVTC Center for Excellence at Four Training Centers	1,800,000		1,400,000		3,200,000	
Implement Southern Virginia Regional Community Capacity Initiative	6,010,000		4,625,000		10,635,000	
Implement Eastern Virginia Regional Community Capacity Initiative	8,299,302	1,229,270**	8,299,302	1,229,270**	16,598,604	2,458,540**
Implement Crisis Stabilization Programs in Region IV and Region I	1,443,174		1,111,200		2,554,374	
Provide Targeted MH and SA Services in Jails and Juvenile Detention Centers	1,471,832		1,471,832		2,943,664	
Create a Secure Juvenile MH Treatment Program	6,903,952		1,840,051		8,744,003	
Increase the Number of Human Rights Advocates	340,000		680,000		1,020,000	
Increase the Number of Licensing Specialists	245,450		225,450		470,900	

Proposed Initiative or Request	FY 2003 SGF	FY 2003 NGF	FY 2004 SGF	FY 2004 NGF	Biennium Total SGF	Biennium Total NGF
Achieve Compliance with HIPAA	3,410,004		1,288,004		4,698,008	
Implement a Sexually Violent Predators Program	9,945,149		4,899,049		14,844,198	
Address Increased State Facility Energy Costs	2,000,000		2,000,000		4,000,000	
Fund Phase Two FMS II Implementation	217,375		161,775		379,150	
Address General Fund Medicaid Match Shortfall	13,700,000		13,700,000		27,400,000	
Address Existing ESH Budget Shortfall	1,200,000		1,200,000		2,400,000	
TOTAL	$92,002,065	$13,724,635	$91,092,352	$19,855,314	$183,094,417	$22,552,949

Notes:

* These funds would be appropriated to the Department of Medical Assistance Services.

** Non-general funds include anticipated Medicaid and third party payer fees, direct client fees, and other revenues for community services.

TERRORISM-RELATED SERVICE AND INFRASTRUCTURE REQUIREMENTS

On September 11, 2001, the United States experienced devastating and horrific terrorist attacks on the World Trade Center buildings in New York City, the crash of a highjacked United plane in Pennsylvania, and the extensive damage to the Pentagon in Arlington County, Virginia. From the first reports at 8:40 a.m, each of these attacks was reported live before a stunned world-wide audience. These attacks represented the first of a series of assaults on America's safety and security. Though relatively little media attention has been given to the impact of the explosion at the Pentagon as compared to the destruction of the World Trade Center or the earlier Oklahoma City bombing, the death toll was substantial and many Virginians have been directly or indirectly affected.

Virginia is uniquely situated to be a target for terrorist attacks. Its citizens are vulnerable to air attacks, bio-terrorism, bombs, and other known and unknown forms of purposeful mass and targeted destruction. As neighbors to the Federal Government and all of its related partners, contractors, and constituent representatives, the Northern Virginia area has proven to be a prime target. Additionally, Northern Virginia is home to a significant portion of the digital and telecommunications world-wide industry. The greater Tidewater area of Virginia is home to a large conglomeration of military installations, including the largest military naval base in the world. The Central Virginia area also contains significant military installations.

These terrorist attacks have affected families across Virginia, including families with loved ones in the military or in the National Guard whose units have been called to duty. Many other Virginians also have experienced feelings of fear for their personal and family safety. These feelings have been heightened by widespread media coverage of the terrorist attacks, the abrupt change that has occurred in the regional economy, and the ongoing anthrax threats.

The events that began on September 11th also can stimulate, and in fact have already triggered, psychotic behavior in vulnerable populations, including adults with serious mental illnesses, children with

serious emotional disturbances, and individuals with existing substance abuse problems. The service and support needs of these at-risk populations will continue to change over time. Consequently, long-term mental health and substance abuse services that are comprehensive and far reaching are an important element of the recovery process.

Following the terrorist attacks of September 11, 2001, the Department received $50,000 in federal funds to assess terrorism-related mental health service needs in Virginia. The completed *Virginia Terrorism-Related Mental Health Needs Assessment* was submitted to the Center for Mental Health Services (CMHS) of the Department of Health and Human Services (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA) on November 26, 2001.

Survey of Community Organization Response Activities and Mental Health and Substance Abuse Disaster Response Service Needs in Northern Virginia

This assessment described mental health and substance abuse interventions in the Northern Virginia region since the September 11th attacks. It also identified specific service capacity requirements for individuals who need short-term and longer-term assistance in dealing with the September 11th terrorist attack and its aftermath. The Northern Virginia CSBs estimated that 35,776 residents in the areas they serve may need mental health or substance abuse services as a result of the September 11th terrorist attacks and subsequent bio-terrorist threats and events. These CSBs provided detailed projections of needed mental health and substance abuse services, based on their experience to date.

The needs assessment included structured key informant interviews of 72 Northern Virginia organizations, including the American Red Cross; Salvation Army; CSBs; local police, fire and rescue, health, human, and social services agencies; private mental health and substance abuse providers; and community and faith-based organization. These organizations were asked about services they provided and planned to provide to specific population groups in response to the September 11th attack. They also were asked to provide numbers of individuals who sought mental health or substance abuse services and whether such services were available to them. This survey was conducted during the last weeks of October and the first week of November 2001.

The 72 community and mental health organizations participating in the survey estimate that they served over 17,000 people. This is undoubtedly a duplicated count that overstates the actual number of persons served because there was extensive cooperation among the responding organizations. Key informants for 51 organizations reported that they provided assistance to the same people that other community organizations had helped. In all, 69 organizations were identified as helping people who were also helped by the responding organizations. Among the most frequently mentioned organizations were the American Red Cross, CSBs and their community mental health centers, local Departments of Social Services, the Salvation Army, and faith-based organizations.

These organizations reported that they worked with a wide range of people, most frequently:

- Families, friends, and neighbors - reported by 53 organizations;
- Persons living or working in the proximity of the Pentagon or other potential targets - reported by 50 organizations;
- Persons who are unemployed due to terrorist activities - reported by 48 organizations;
- Individuals who, because of their national origin or Islamic faith, have experienced or may feel that they might be targets of misplaced anger or verbal or physical abuse - reported by 44 organizations.

When asked about the types of services they offered, the key informants reported that their organizations provided an array of services in response to the terrorist activities since September 11th. The most frequently mentioned services named by the 72 responding organizations included activities to strengthen the community, crisis counseling, outreach, and activities to strengthen families. Of the participating organizations, 58 indicated that they planned to continue to offer services in the future to persons affected by terrorist activities.

Since the reason for conducting the survey was to assess the need for mental health services, additional analysis was conducted on the mental health key informants' responses. Sixteen mental health organizations that participated in the survey reported that they had served over 4,700 people, a duplicated count given the extent to which the responding organizations reported that they were serving the same people. These 16 organizations represent the five Northern Virginia CSBs, two specialized programs within the CSBs, two employee assistance programs, five private providers, and two hospitals offering mental health services.

To derive an estimate of the unduplicated number of persons served by mental health organizations, the needs assessment made several adjustments to the original estimates. Based on Fairfax County and Immigration and Naturalization Service data, one-third of the "individuals who, because of their national origin or Islamic faith, have experienced of may feel that they might be targets of misplaced anger or verbal or physical abuse" were presumed to overlap with "immigrants who have come to Northern Virginia to get away from conflict and danger." Because the survey responses indicate extensive cooperation among the five Northern Virginia CSBs and the Northern Virginia Mental Health Institute, the unduplicated count assumes 100 percent overlap among these entities. Finally, a value of 200 was assigned to the survey responses of "over 200," which underestimates both the duplicate and unduplicated counts. Given these assumptions, it is conservatively estimated that 3,223 persons received terrorism-related services from mental health organizations.

Proposed Terrorism-Related Services System Enhancements

In addition to the identification of specific service needs in the Northern Virginia region, this needs assessment proposed specific recommendations for service system enhancements at both the state and local levels. These system enhancements, if implemented, would:

- Enable Virginia's mental health, mental retardation, and substance abuse services system to better understand and prepare for the heightened threat potential facing the Commonwealth, and
- Establish structures and relationships that will assure an immediate, effective, and coordinated response to terrorism-related and other major disasters.

The Department convened focus groups in Northern Virginia, Central Virginia, and Tidewater. Each group included public and private mental health and substance abuse providers; state and local emergency management coordinators; police, fire and rescue organizations; the American Red Cross; school system representatives; U.S. Navy Fleet and Family Support Centers; and community and faith-based organizations. Each focus group met twice to describe lessons learned from Virginia's current experience in responding to the September 11th attack, assess gaps in Virginia's current mental health and substance abuse disaster response capability, identify gaps and vulnerabilities regarding future terrorist attacks, and recommend service system enhancements.

Recommendations for system level enhancements and strategies were made in the following areas: planning and preparedness, data collection and needs assessment, outreach and public education, school-based preparedness and response, and mental health and substance abuse services response.

Special Psychiatric Immediate Response, Intervention, and Treatment (SPIRIT) Teams

The needs assessment included specific recommendations for the development and implementation of Special Psychiatric Immediate Response, Intervention, and Treatment (SPIRIT) Teams in Virginia. These teams would provide a regionally-based structure to prepare for, organize, and activate an immediate psychiatric response that will provide intensive mental health intervention and treatment to first responders and victims of catastrophic events. Four SPIRIT Teams are recommended, three in the densely populated regions of Northern Virginia, Central Virginia, and Tidewater, and the fourth in southwestern Virginia.

Recommended Terrorism-Related Service and Infrastructure Requirements

The needs assessment recommended statewide service and infrastructure requirements that must be in place to respond to the new challenges and responsibilities of the Department and community services boards associated with terrorism-related actions. With the September 11th terrorist attack and subsequent events, the current missions of state mental health authorities and CSBs have been challenged. Along with maintaining traditional responsibilities for serving adults with the most serious mental illnesses and youth with serious emotional disturbance, state and local mental health providers are finding themselves called upon to provide outreach and targeted interventions to persons in the general public who are experiencing fears, anxieties, and depression arising from the recent terrorism events.

Because many individuals will not seek services from mental health providers, CSBs will need to provide targeted interventions with and support to and through a variety of community organizations (including churches, schools, and civic associations) to which people who have been affected by terrorism will turn for assistance and support. Many of these community organizations are not equipped to provide needed levels of assistance and support on their own. CSBs will not be able to assume this additional mental health tertiary prevention responsibility without new resources.

Experience from Oklahoma City indicates that mental health and substance abuse needs are likely to increase substantially over the next year and will last for an extended period of time. An effective and appropriate response to these needs and new responsibilities by state mental health and substance abuse authorities should be supported financially by the federal government as part of its national defense responsibilities to combat and respond to terrorism.

Because the magnitude and duration of this event is unprecedented, it is almost impossible to accurately predict the future mental health and substance abuse service needs that will result from the terrorist attacks of September 11th and subsequent bio-terrorist threats and actions. The Department has identified a number of specific service and infrastructure requirements totaling $53,835,758. These requirements would:

- Respond to anticipated long-term mental health and substance abuse service needs resulting from the attacks of September 11th and the continuing terrorist threats and activities; and
- Enable the Commonwealth to implement many of the systemic enhancements and infrastructure recommendations discussed in the needs assessment.

The mental health and substance abuse services listed below incorporate lessons learned from Oklahoma City, input from focus group participants, and recommendations of the SPIRIT Team work group.

- SPIRIT Team development and implementation;
- Development of five regional residential crisis stabilization programs;
- Expanded ability of CSBs across the Commonwealth to provide emergency services;
- Expanded ability of CSBs across the Commonwealth to provide outpatient mental health and substance abuse services;
- Expanded ability of CSBs across the Commonwealth to provide mental health and substance abuse case management services;
- Expanded ability of CSBs to provide targeted longer-term critical incident stress management follow-up services for September 11th first responders;
- Development and dissemination of information that promotes public awareness and education on terrorism response and preparedness in the Commonwealth;
- Expanded behavioral consultation services to assist providers of services to persons with mental retardation to address the anxiety and behavioral manifestations associated with this disaster in their consumers;
- Increased availability of psychiatric services across the Commonwealth;
- Enhanced substance abuse diversion and hospital-based detoxification services;
- Expanded ability of CSBs across the Commonwealth to provide in-home mental health and substance abuse services for children, adolescents and families;
- Increased capacity of existing Programs of Assertive Community Treatment (PACT) teams to provide substance abuse services;
- Development of specialized assertive community treatment for consumers with dual diagnoses of mental illness and substance abuse or dependence in Northern Virginia;
- Expanded ability of CSBs to provide residential and respite services for children, adolescents, and families;
- Expanded ability of CSBs to provide prevention services and support prevention training and technical assistance activities;
- Support for the development and implementation of targeted training for mental health and substance abuse professionals to enhance their ability to effectively and appropriately respond to terrorism and its impact on consumers, responders and aid workers, families, and communities; and
- Establishment and support for planning and coordination of disaster response and recovery activities.

Appendix H provides a detailed listing of terrorism-related service and infrastructure needs identified by the Department.

VI. Conclusion

This document responds to the requirement in §37.1-48.1 of the *Code of Virginia* for a six-year Comprehensive State Plan for mental health, mental retardation, and substance abuse services that identifies the services and supports needs of persons with mental illnesses, mental retardation or alcohol or other drug dependence or abuse problems across the Commonwealth; defines resource requirements; and proposes strategies to address these needs. The directions established in the *Comprehensive State Plan for 2002-2008* would enable the Commonwealth to accelerate the shift to a more community-based system while preserving the important roles and service responsibilities of state mental health and mental retardation facilities in Virginia's public services system.

In this plan, the Department continues to emphasize the transition toward a community-based system of care where services emphasize each consumer's movement toward recovery, self-determination, and integration into life and work in the community, to the extent possible given the nature of his disability and individual circumstances. State mental health and mental retardation facilities will continue to play an important role in this community-based system of care. State facilities will continue to provide extended and intensive longer-term rehabilitation and habilitation services and a full range of inpatient forensic mental health services. Even with the transition of acute psychiatric inpatient services from state mental health facilities to community hospitals where possible, state mental health facilities will continue provide acute psychiatric services to individuals for whom local acute psychiatric services in community hospitals are not available or appropriate for their needs.

A delicate balance has been achieved between state facility and community services. On the state facility side, this balance is based on smaller community demand for state hospital inpatient psychiatric services, reduced state facility average daily censuses, improved quality of state facility care, and slightly larger appropriations. On the community side, this balance is based on greatly increased appropriations, expanded targeted services, diversions of inappropriate state facility admissions, and more use of private sector inpatient psychiatric beds. This balance is founded on current policy directions, economics in the public and private sectors, and the need to:

- Maintain quality and protect services in state facilities in order to avoid greater costs from future court consent decrees or Olmstead-related decisions;
- Sustain the capacity of CSBs; and
- Continue support and development of targeted services.

While the past four years have been characterized by broad-based growth and expansion in an extremely favorable economic climate, that climate is changing dramatically as a result of the deceleration of the economy that began this summer and has continued in the aftermath of the tragic events of September 11th. To the extent possible, the policy agenda for publicly-funded mental health, mental retardation, and substance abuse services for the next biennium needs to focus on two key themes:

- Sustainability of the progress that has been achieved, especially for consumers and family members who have benefited from the expansion and improvement of services during the past four years; and
- Clearly focused growth and development efforts to address, to the extent possible, the critical issues facing Virginia's mental health, mental retardation, and substance abuse services system.

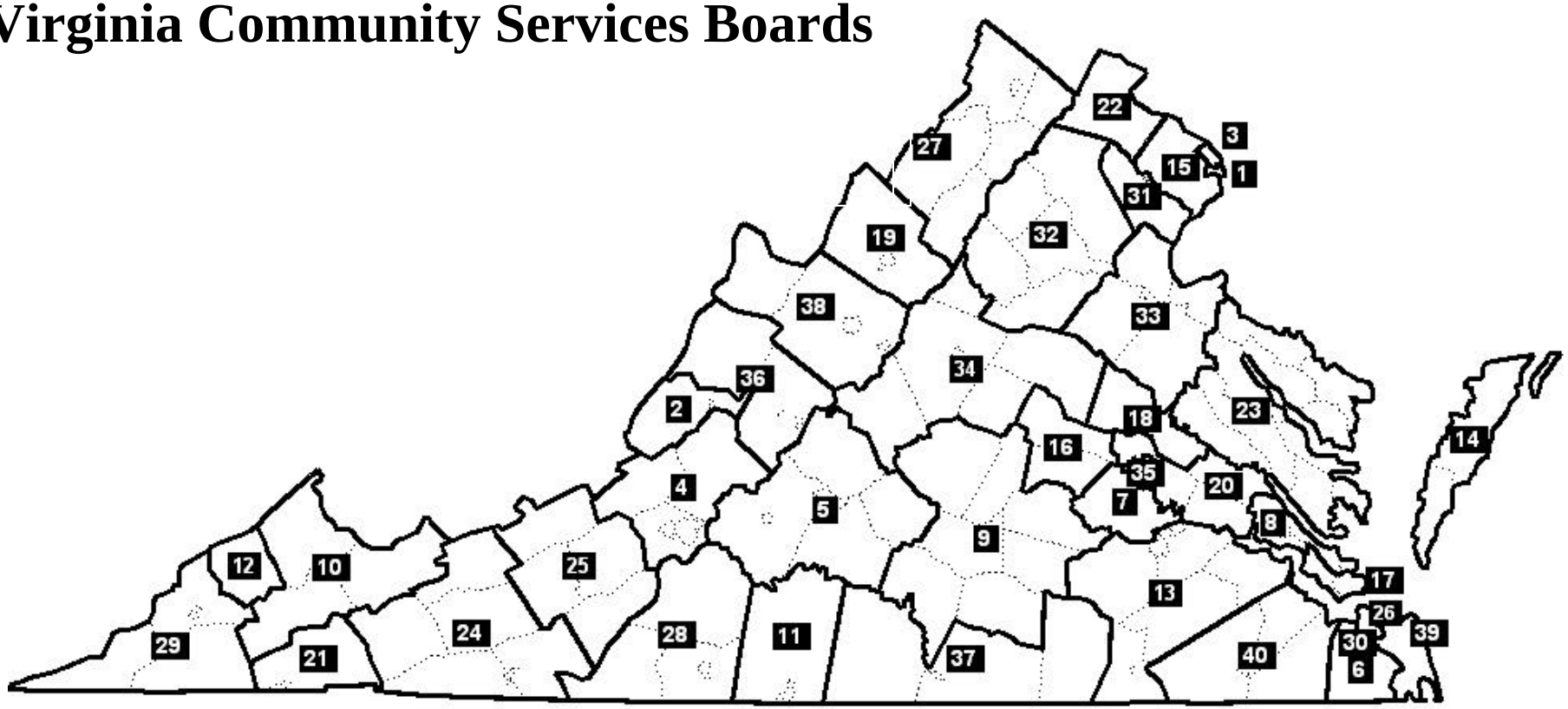
The *Comprehensive State Plan for 2002-2008* continues the direction set forth in the *2000-2006*

Comprehensive State Plan to change an essentially open-ended services system into one that targets resources to those who need services the most and to increase community options and consumer choice; supports opportunities for consumer and family member education, training and participation; promotes collaborative activities with other agencies and services systems and private sector development; improves services oversight and accountability; advances quality improvement and care coordination; and addresses system administrative and infrastructure issues.

Appendix A

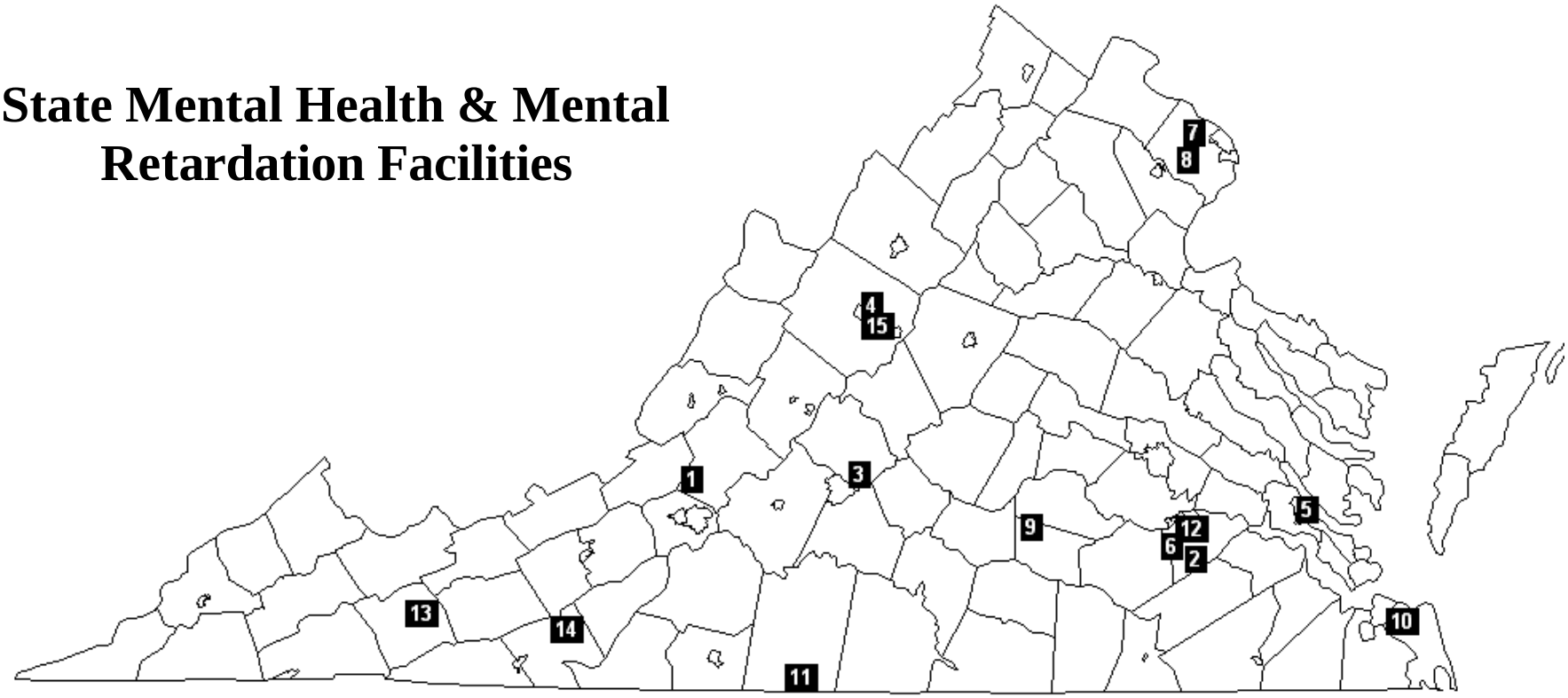
Maps of Community Services Boards and State Mental Health and Mental Retardation Facility Service Areas

Virginia Community Services Boards



1	Alexandria	11	Danville-Pittsylvania	21	Highlands	31	Prince William
2	Alleghany Highlands	12	Dickenson	22	Loudoun	32	Rappahannock-Rapidan
3	Arlington	13	District 19	23	Mid Peninsula-Northern Neck	33	Rappahannock Area
4	Blue Ridge	14	Eastern Shore	24	Mount Rogers	34	Region Ten
5	Central Virginia	15	Fairfax-Falls Church	25	New River Valley	35	Richmond
6	Chesapeake	16	Goochland-Powhatan	26	Norfolk	36	Rockbridge Area
7	Chesterfield	17	Hampton-Newport News	27	Northwestern	37	Southside
8	Colonial	18	Hanover	28	Piedmont	38	Valley
9	Crossroads	19	Harrisonburg-Rockingham	29	Planning District 1	39	Virginia Beach
10	Cumberland Mountain	20	Henrico Area	30	Portsmouth	40	Western Tidewater

State Mental Health & Mental Retardation Facilities



	Facility	Location		Facility	Location
1	Catawba Hospital (CH)	Catawba	8	Northern VA Training Center (NVTC)	Fairfax
2	Central State Hospital (CSH)	Petersburg	9	Piedmont Geriatric Hospital (PGH)	Burkeville
3	Central VA Training Center (CVTC)	Madison Heights	10	Southeastern VA Training Center (SEVTC)	Chesapeake
4	Commonwealth Center for Children and Adolescents (CCCA)	Staunton	11	Southern VA Mental Health Institute	Danville
5	Eastern State Hospital (ESH)	Williamsburg	12	Southside VA Training Center	Petersburg
6	Hiram W. Davis Medical Center (HWDMC)	Petersburg	13	Southwestern VA MH Institute	Marion
7	Northern VA MH Institute (NVMHI)	Falls Church	14	Southwestern VA Training Center	Hillsville

Appendix B
Community Services Board Services Utilization and Condensed Core Services Taxonomy 6 Definitions

Community services boards (CSBs) offer varying combinations of six core services, directly and through contracts with other organizations. Tables 1 and 2 display the growth of community services, by program area. Tables 3, 4, 5, and 6 display information about consumers served, static capacities, units of service provided, and consumer levels of functioning in SFY 2000, which started on July 1, 1999. Table 7 displays trends in numbers of consumers served between SFY 1986 and 2000. Services, beds, and slots are defined in Core Services Taxonomy 6. All tables show actual data, derived from 4th quarter performance reports submitted by CSBs.

TABLE 1: CONSUMERS SERVED BY COMMUNITY SERVICES BOARDS [1]

Fiscal Year	Mental Health	Mental Retardation	Substance Abuse	Total
1986	135,182	20,329	52,942	208,453
1988	161,033	22,828	80,138	263,999
1990	152,811	30,198	101,816	284,825
1992	160,115	27,525	78,358	265,998
1994	168,208	28,680	87,166	284,054
1996	174,126	30,006	90,750	294,882
1998	185,647	32,509	96,556	314,712
2000	180,783	26,086	88,358	295,227

TABLE 2: STATIC CAPACITIES IN COMMUNITY SERVICES BOARD PROGRAMS [2]

Fiscal Year	Mental Health		Mental Retardation		Substance Abuse	
	Beds	Slots	Beds	Slots	Beds	Slots
1986	706	1,772	792	5,106	715	181
1988	688	1,820	948	2,581	679	105
1990	942	2,189	1,282	2,847	877	338
1992	994	1,925	1,276	2,768	873	366
1994	1,096	1,888	1,322	3,152	896	418
1996	1,004	2,128	1,435	3,904	1,124	387
1998	836	2,534	1,403	3,884	1,058	373
2000	828	2,371	751	2,144	975	319

NOTES:

1. Consumers served are not unduplicated numbers of individuals. Some receive more than one type of service within a program area and sometimes receive services in more than one program area.
2. Many decreases in static capacities result from changes in definitions and improved accuracy in reporting. For example, static capacity in MR day support changed from number of clients to number of slots.
3. In several instances, decreases in static capacity result from shifts in program resources. For example, the decline in mental retardation slots reflects moving resources from sheltered employment, measured in slots, to supported employment services, an hourly service with no static capacity. The increase in FY 1994 reflects the addition of another day support subcategory, group model supported employment, that does count slots.

TABLE 3: COMMUNITY SERVICES BOARD CONSUMERS SERVED IN FY 2000 BY CORE SERVICE

Program Area / Core Service	Mental Health	Mental Retardation	Substance Abuse	TOTAL
Emergency Services	47,881	10	9,337	57,228
Local Inpatient	1,554		12	1,566
Community Hospital-Based Detox			135	135
TOTAL Local Inpatient Services	1,554		147	1,701
Outpatient Services	78,520	144	43,889	122,553
Intensive In-Home Services	2,077			2,077
Case Management	37,510	10,701	13,660	61,871
Assertive Community Treatment	263			263
Methadone Detoxification			411	411
Opioid Replacement Therapy			1,493	1,493
TOTAL Outpatient & Case Management	118,370	10,845	59,453	188,668
Day Treatment/Partial Hospitalization	587		1,946	2,533
Therapeutic Day Treatment - C&A	820			820
Rehabilitation Services	5,234	533		5,767
Sheltered Employment Services	73	1,329		1,402
Supported/Transitional Employment	705	1,428		2,133
Supported Employment - Group Models	21	598		619
Alternative Day Support Arrangements	257	755	241	1,253
TOTAL Day Support Services	7,697	4,643	2,187	14,527
Highly Intensive Residential Services	310	59	7,108	7,477
Intensive Residential Services	259	241	4,527	5,027
Supervised Residential Services	1,809	355	252	2,416
Supportive Residential Services	2,038	1,212	877	4,127
Family Support Services	67	2,183	172	2,422
TOTAL Residential Services	4,483	4,050	12,936	21,469
Early Intervention Services	798	6,538	4,298	11,634
TOTAL Consumers Served [1]	180,783	26,086	88,358	295,227
TOTAL Unduplicated Consumers	118,210	22,036	61,361	201,607

[1] Consumers served are not unduplicated numbers of individuals. Some consumers receive more than one type of service and sometimes receive services in more than one program area.

TABLE 4: COMMUNITY SERVICES BOARD STATIC CAPACITIES IN FY 2000 BY CORE SERVICE

Program Area / Core Service	Mental Health	Mental Retardation	Substance Abuse	TOTAL
Local Inpatient	28		0	28
Community Hospital-Based Detox			4	4
TOTAL Local Inpatient Services Beds	28		4	32
Day Treatment/Partial Hospitalization	108		319	427
Therapeutic Day Treatment - C&A	351			351
Rehabilitation Services	1,860	484		2,344
Sheltered Employment Services	35	1,149		1,184
Supported Employment - Group Models	17	511		528
TOTAL Day Support Services Slots	2,371	2,144	319	4,834
Highly Intensive Residential Services	57	65	208	330
Intensive Residential Services	131	425	674	1,230
Supervised Residential Services	612	261	93	966
TOTAL Residential Services Beds	800	751	975	2,526

TABLE 5: COMMUNITY SERVICES BOARD SERVICES PROVIDED IN FY 2000 BY CORE SERVICE

Program Area / Core Service/Unit of Service	Mental Health	Mental Retardation	Substance Abuse	TOTAL
Emergency Consumer Service Hours	312,232	342	56,252	368,826
Local Inpatient	10,256		39	10,295
Community Hospital-Based Detox			723	723
TOTAL Local Inpatient Service Bed Days	10,256		762	11,018
Outpatient Services	781,237	2,689	510,296	1,294,222
Intensive In-Home Services	225,777			225,777
Case Management	648,634	265,742	131,184	1,045,560
Assertive Community Treatment	39,783			39,783
Methadone Detoxification			13,786	13,786
Opioid Replacement Therapy			67,787	67,787
TOTAL OP & CM Cons. Service Hours	1,695,431	268,431	723,053	2,686,915
Day Treatment/Partial Hospitalization	87,609		318,719	406,328
Therapeutic Day Treatment - C&A	305,940			305,940
Rehabilitation Services	2,516,387	485,751		3,002,138
TOTAL Day Support Hours	2,909,936	485,751	318,719	3,714,406
Sheltered Employment Services	10,947	205,247		216,194
Supported Employment - Group Models	1,904	98,707		100,611
TOTAL Day Support Days of Service	12,851	303,954		316,805
Supported/Transitional Employment	33,932	122,389		156,321
Alternative Day Support Arrangements	7,594	61,522	10,696	79,812
TOTAL Day Support Cons. Service Hours	41,526	183,911	10,696	236,133
Highly Intensive Residential Services	10,757	20,256	50,720	81,733
Intensive Residential Services	40,623	78,818	201,677	321,118
Supervised Residential Services	189,616	79,260	27,377	296,253
TOTAL Residential Bed Days	240,996	178,334	279,774	699,104
Supportive Residential Services	140,726	134,200	15,962	290,888
TOTAL Residential Cons. Service Hours	140,726	134,200	15,962	290,888
Prevention Services	35,974	4,399	270,706	311,079
Early Intervention Services	16,100	232,591	33,117	281,808
TOTAL Prev. & E.I. Cons. Service Hours	52,074	236,990	303,823	592,887

TABLE 6: LEVELS OF FUNCTIONING/DISABILITY FOR CONSUMERS SERVED BY CSBs IN FY 2000

Mental Health			Substance Abuse			Mental Retardation	
Axis 5	**Number**	**Percent**	**Axis 5**	**Number**	**Percent**		
81 - 90	771	0.73	81 - 90	525	0.96		
71 - 80	3,595	3.40	71 - 80	2,560	4.66	**Mild**	4,236
61 - 70	15,874	15.01	61 - 70	9,596	17.46	Percent	42.74
51 - 60	35,434	33.50	51 - 60	19,462	35.41	**Moderate**	3,161
41 - 50	28,112	26.58	41 - 50	14,541	26.46	Percent	31.89
31 - 40	12,394	11.72	31 - 40	4,054	7.38	**Severe**	1,568
21 - 30	6,130	5.79	21 - 30	3,374	6.14	Percent	15.82
11 - 20	2,564	2.42	11 - 20	571	1.04	**Profound**	947
1 - 10	908	0.86	1 - 10	280	0.51	Percent	9.55
TOTAL	105,782	100.00	**TOTAL**	54,963	100.00	**TOTAL**	9,912
						Percent	100.00
Unknown [1]	12,428		**Unknown** [1]	6,398		**Unknown** [2]	8,611
NOTE [3]	118,210		**GRAND TOTALS**	61,361		NOTE [4]	18,523

All figures above reflect *unduplicated* consumer counts.

NOTES:

1. Most unknowns received emergency services, where it is often difficult to obtain information about level of functioning due to the nature of this service.
2. Includes unknown for 6,127 infants or toddlers in early intervention services for whom determining a level of disability is not appropriate.
3. Of this total, 84,224 adults were identified as having serious mental illnesses and 24,055 children and adolescents were identified as having serious emotional disturbances.
4. The difference between the grand total shown here and the total unduplicated number of consumers with mental retardation (22,036) shown in preceding tables is the result of collecting levels of care rather than mild, moderate, severe, and profound levels of functioning for consumers in the Medicaid MR Home and Community-Based Waiver (3,513 individuals).

TABLE 7: TRENDS IN NUMBERS OF INDIVIDUALS SERVED BY CSBS

FY	Mental Health		Mental Retardation		Substance Abuse		TOTAL	
	Undupl.	Dupl.	Undupl.	Dupl.	Undupl.	Dupl.	Undupl.	Dupl.
1986	NA	135,182	NA	20,329	NA	52,942	NA	208,453
1987	NA	136,440	NA	22,336	NA	60,169	NA	218,945
1988	110,082	161,033	14,354	22,828	57,363	80,138	181,799	263,999
1989	107,892	157,825	17,361	27,610	62,905	87,878	188,158	273,313
1990	NA	152,811	NA	30,198	NA	101,816	NA	284,825
1991	NA	161,536	NA	28,539	NA	103,288	NA	293,363
1992	NA	160,115	NA	27,525	NA	78,358	NA	265,998
1993	105,389	158,115	19,010	27,696	55,871	80,271	180,270	266,082
1994	107,131	168,208	19,742	28,680	59,471	87,166	186,344	284,054
1995	106,637	177,320	18,572	29,141	61,463	88,471	186,672	294,932
1996	116,344	174,126	19,169	30,006	64,309	90,750	199,822	294,882
1997	115,169	179,500	20,557	30,655	63,040	90,099	198,766	300,254
1998	119,438	185,647	20,983	32,509	68,559	96,556	208,980	314,712
1999	112,729	178,334	21,772	33,087	64,899	93,436	199,400	304,857
2000	118,210	180,783	22,036	26,086	61,361	88,358	201,607	295,227

NOTES:

1. Unduplicated counts of consumers were not collected by the Department every year. The NA notations show years in which this information was not collected.

2. Unduplicated (**Undupl.**) numbers of individuals are the total number of consumers receiving services in a program (mental health, mental retardation, and substance abuse services) area, regardless of how many services they received. If a person with a dual diagnosis (e.g., mental illness and substance abuse) received services in both program areas, he would be counted twice.

3. Duplicated (**Dupl.**) numbers of individuals are the total numbers of consumers receiving each category or subcategory of core services. Thus, if a person received outpatient, rehabilitation, and supervised residential services, he would be counted three times, since he received three services. These totals are added to calculate a total number for each program area.

CONDENSED CORE SERVICES TAXONOMY 6 DEFINITIONS

EMERGENCY SERVICES are unscheduled, and in some instances scheduled (e.g., crisis stabilization), mental health, mental retardation, or substance abuse services, available 24 hours per day and seven days per week, that provide crisis intervention, stabilization, and referral assistance over the telephone or face-to-face, if indicated, to individuals seeking such services for themselves or others. Emergency services may include walk-ins, home visits, jail interventions, and pre-admission screenings and other activities for the prevention of institutionalization or associated with the judicial commitment process.

LOCAL INPATIENT SERVICES deliver mental health or substance abuse services on a 24 hour per day basis in a hospital setting.

- ***Acute Psychiatric or Substance Abuse*** services provide intensive short term psychiatric treatment, including services to persons with mental retardation, or substance abuse treatment, except for detoxification, in local hospitals through contractual arrangements. These services may include intensive stabilization, evaluation, chemotherapy, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.

- ***Community-Based Substance Abuse Medical Detoxification*** services use medication under the supervision of medical personnel to systematically eliminate or reduce effects of alcohol or other drugs in the body in local hospitals or other 24 hour care facilities.

OUTPATIENT AND CASE MANAGEMENT SERVICES provide mental health, mental retardation or substance abuse services, generally in sessions of less than three consecutive hours, to individuals in a non-residential setting.

- ***Outpatient*** services are generally provided to consumers on an hourly schedule, on an individual, group, or family basis. Outpatient services may include diagnosis and evaluation, intake and screening, counseling, psychotherapy, behavior management, psychological testing and assessment, and medication services, which include prescribing and dispensing medications and medication management.

- ***Intensive In-home*** services are time-limited (usually between two and six months) family preservation interventions for children and adolescents with or at risk of serious emotional disturbance, including such individuals who also have a diagnosis of mental retardation. In-home services are provided typically but not solely in the residence of an individual who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement. These services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24 hour per day emergency response.

- ***Methadone Detoxification*** services combine outpatient treatment with the administering or dispensing of methadone as a substitute narcotic drug in decreasing doses to reach a drug free state in a period not to exceed 180 days.

- ***Methadone Maintenance*** services combine outpatient treatment with the administering or dispensing of methadone as a substitute narcotic drug at relatively stable dosage levels for a period in excess of 180 days.

- ***Case Management*** services assist individuals and their family members in accessing needed services that are responsive to individual needs. Services include: identifying and reaching out to potential consumers; assessing needs and planning services; linking the individual to services and supports; assisting the person directly to locate, develop or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; and advocating for people in response to their changing needs.

DAY SUPPORT SERVICES provide structured programs of treatment, activity, or training services, generally in clusters of two or more continuous hours per day, to groups or individuals in a non-residential setting.

- ***Day Treatment/Partial Hospitalization*** is a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with serious mental or alcohol or other drug abuse disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment of pathological conditions that is not provided in outpatient services.

- ***Therapeutic Day Treatment for Children and Adolescents*** is a treatment program that serves children and adolescents (ages 0 through 17) with serious emotional disturbances or children at risk (ages 0 through 6) of serious emotional disturbance in order to combine psychotherapeutic interventions with education and mental health treatment. Services include: evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills; and individual, group, and family counseling.

- ***Rehabilitation*** programs include a variety of training opportunities in two modalities.

  Psychosocial rehabilitation programs provide certain basic opportunities and services - assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy - in a supportive environment in the community focusing on normalization. Psychosocial rehabilitation emphasizes strengthening the person's abilities to deal with everyday life rather than focusing on treating pathological conditions.

  Day Health and Rehabilitation programs provide planned combinations of individualized activities, supports, training, supervision, and transportation to people with mental retardation to improve their condition or to maintain an optimal level of functioning as well as to ameliorate the individual's disabilities or deficits by reducing the degree of impairment or dependency. Specific components of this service develop or enhance the following skills: self care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, and medication management, and transportation.

- ***Sheltered Employment or Work Activity*** programs provide work in a non-integrated setting that is compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting. This service also includes the development of social, personal, and work-related skills based on an individualized consumer service plan.

- ***Supported Employment-Group Model*** programs provide work to a small group (three to eight people) of individuals at a job site in the community or at dispersed sites within an integrated setting. Integrated setting means opportunities exist for consumers in the immediate work setting for regular contact with non-disabled individuals who are not providing support services. The consumers may be employed by the employer or by the vendor of supported employment services. Ongoing support services are provided by an employment specialist who may be employed by the employer or by the vendor. Models include mobile and stationary crews, enclaves, and small businesses (entrepreneurial).

- ***Supported Employment*** programs provide work to a single consumer placed in an integrated work setting in the community. The consumer is employed by the employer. On-going support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the consumer in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals.

- ***Alternative Day Support Arrangements*** are day support alternatives not included in the preceding subcategories. They assist people to locate day support settings and may provide program staff, follow along, or assistance to these individuals. The focus may be on assisting the person to maintain an independent day support arrangement. This subcategory also includes *Education/Recreation* services providing education, recreation, enrichment, and leisure activities daily, weekly, or monthly, during the summer or throughout the year.

RESIDENTIAL SERVICES provide overnight care in conjunction with an intensive treatment or training program in a setting other than a hospital or training center or overnight care in conjunction with supervised living or other supportive residential services.

- ***Highly Intensive Residential Services*** provide overnight care in conjunction with intensive treatment or training services. These services include: Mental Health Residential Treatment Centers such as short term intermediate care, crisis stabilization, residential alternatives to hospitalization, and dually diagnosed programs where intensive treatment rather than just supervision occurs; Intermediate Care Facilities for Mentally Retarded persons (ICF/MR) that deliver active habilitative and training services in a ***community*** setting; and Social Detoxification Programs that systematically reduce or eliminate the effects of alcohol or other drugs in the body (returning the person to a drug-free state) in a *specialized non-medical facility* with physician services available when required and normally last up to seven days.

- ***Intensive Residential Services*** provide overnight care in conjunction with treatment or training that is less intense than the first subcategory and include the following types of services.

  Primary Care offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psychoeducation, consumer monitoring, case management, individual and family therapy, and discharge planning.

  Intermediate Rehabilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay up to 90 days. Services include supportive group therapy, psychoeducation, consumer monitoring, case management, individual and family therapy, employment services, and community preparation services.

  Long-Term Habilitation is a substance abuse psychosocial therapeutic milieu with an expected stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility. Services include intensive daily group and individual therapy, family counseling, and psychoeducation. Daily living skills and employment opportunities are integral components of the treatment program.

  Group Homes/Halfway Houses are facilities of five or more beds that provide identified beds, supported or controlled by CSBs, and 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting. The expected length of stay normally exceeds 30 days.

- ***Supervised Residential Services*** offer overnight care in conjunction with supervision and services and include the following types of services.

  Supervised Apartments are directly-operated or contractual, licensed or unlicensed, residential programs that place and provide services to individuals in units that are owned, rented, leased, or otherwise controlled by the licensed service provider. The length of stay normally exceeds 30 days.

  Domiciliary Care provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay

exceeding 30 days. Domiciliary care is a less intensive program than a group home or supervised apartment; an example would be a licensed adult care residence funded by a community services board.

Emergency Shelter/Residential Respite programs provide identified beds, supported or controlled by CSBs, in a variety of settings reserved for short term stays, usually several days to no more than 21 consecutive days.

Sponsored Placements place people in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include individualized therapeutic homes, specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual consumer residential placements with an expected stay exceeding 30 days.

- ***Supportive Residential Services*** are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an **hourly** basis.

  In-Home Respite provides care in the homes of people with mental disabilities or in a setting other than that described in residential respite services above. This care may last from several hours to several days and allows the family member care giver to be absent from the home.

  Supported Living Arrangements are residential alternatives not included in other types of residential services. They assist people to locate or maintain residential settings where access to beds is not controlled by CSBs and may provide program staff, follow along, or assistance to the person. The focus may be on assisting the individual to maintain an independent residential arrangement. Examples include homemaker services, public-private partnerships, PATH grant outreach and support services, and non-CSB subsidized apartments (e.g., HUD certificates).

- ***Family Support*** offers assistance for families who choose to provide care at home for family members with mental disabilities. Family support is a combination of financial assistance, services, and technical supports that allows families to have control over their lives and the lives of their family members. The support should be flexible and individualized to meet the unique needs of the family and the individual with the disability. Family support services may include respite care, adaptive equipment, personal care supplies and equipment, behavior management, minor home adaptation or modification, day care, and other extraordinary needs.

PREVENTION AND EARLY INTERVENTION SERVICES are designed to prevent or intervene early in the process of mental illness, mental retardation, or substance abuse.

Prevention services involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of mental illness, mental retardation and other developmental disabilities, and alcohol and other drug dependency and abuse. The emphasis is on the enhancement of protective factors and the reduction of risk factors. *Information Dissemination* provides awareness and knowledge of the nature and extent of mental illness, mental retardation, and alcohol and other drug dependency and abuse. *Prevention Education* aims to affect critical life and social skills, including general competency building, specific coping skills training, support system interventions, strengthening caregivers, and decision-making skills training. *Alternatives* provide for the participation of specific populations in activities that are constructive, promote healthy choices, and provide opportunities for skill building. *Problem Identification and Referral* aims at the identification of those individuals who are most at risk of developing problematic behaviors in order to assess if their behaviors can be changed though prevention education. *Community-based Process* aims at enhancing the ability of the community to more effectively provide prevention and treatment services. *Environmental* prevention programs and activities establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the development

of healthy living conditions.

- ***Early Intervention*** services are intended to improve functioning or change behavior in those people identified as beginning to experience problems, symptoms, or behaviors which without intervention are likely to result in the need for treatment. Early intervention services are generally targeted to identified individuals or groups. Examples of early intervention services may include: case consultation, groups for adolescents who have been suspended for use of alcohol or tobacco, and programs for children or adults exhibiting behavior changes following loss such as divorce, death of a loved one, and job loss.

  Early Intervention includes *Infant and Toddler Intervention*, which provides family-centered, community-based early intervention services designed to meet the developmental needs of infants and toddlers and the needs of their families as these needs relate to enhancing the child's development. These services also prevent or minimize the potential of developmental delays and increase the capacity of families to meet the needs of their at-risk infants and toddlers. Infant and toddler intervention is delivered through a comprehensive, coordinated, interagency, and multi-disciplinary services system. Infant and toddler intervention includes: audiology, family training, counseling and home visits, health, medical, nursing, nutrition, occupational therapy, physical therapy, psychological, special instruction, speech-language pathology, vision, and transportation services.

DEFINITIONS OF STATIC CAPACITIES

Number of Beds: the total number of beds for which the facility or program is licensed and staffed or the number of beds contracted for during the contract period.

Number of Slots: the maximum number of distinct consumers who could be served during a day or a half-day session in most day support programs. It is the number of slots for which the program or service is staffed.

Consumers: the number of consumers will always be the total number of consumers served during the reporting period. The following definitions are used to determine at what point in time an individual is counted as a consumer.

- **Emergency**: upon documented face-to-face contact or telephone contacts during which a person receives counseling.
- **Inpatient:** upon physical residence in the program.
- **Outpatient and Case Management:** upon initial documented face-to-face contact for people for whom a record would normally be opened. For case management services, face-to-face contact is not necessary if records are obtained, a file is opened, and extensive preliminary work is done for a consumer before it is feasible to meet the consumer in a face-to-face situation.
- **Day Support:** upon initial documented attendance or participation in the program, or, for supported employment and alternative day support, upon initial documented face-to-face contact for persons for whom a record would normally be opened.
- **Residential:** upon physical residence in the program, or, for supported services, upon initial documented face-to-face contact for individuals for whom a record would normally be opened.
- **Early Intervention:** upon initial documented attendance or participation in early intervention programs, including infant and toddler intervention.

Appendix C
State Mental Health and Mental Retardation Facility Utilization

State Mental Health Facility Patients Served, Average Daily Census, Admissions, and Separations -- FY 2001

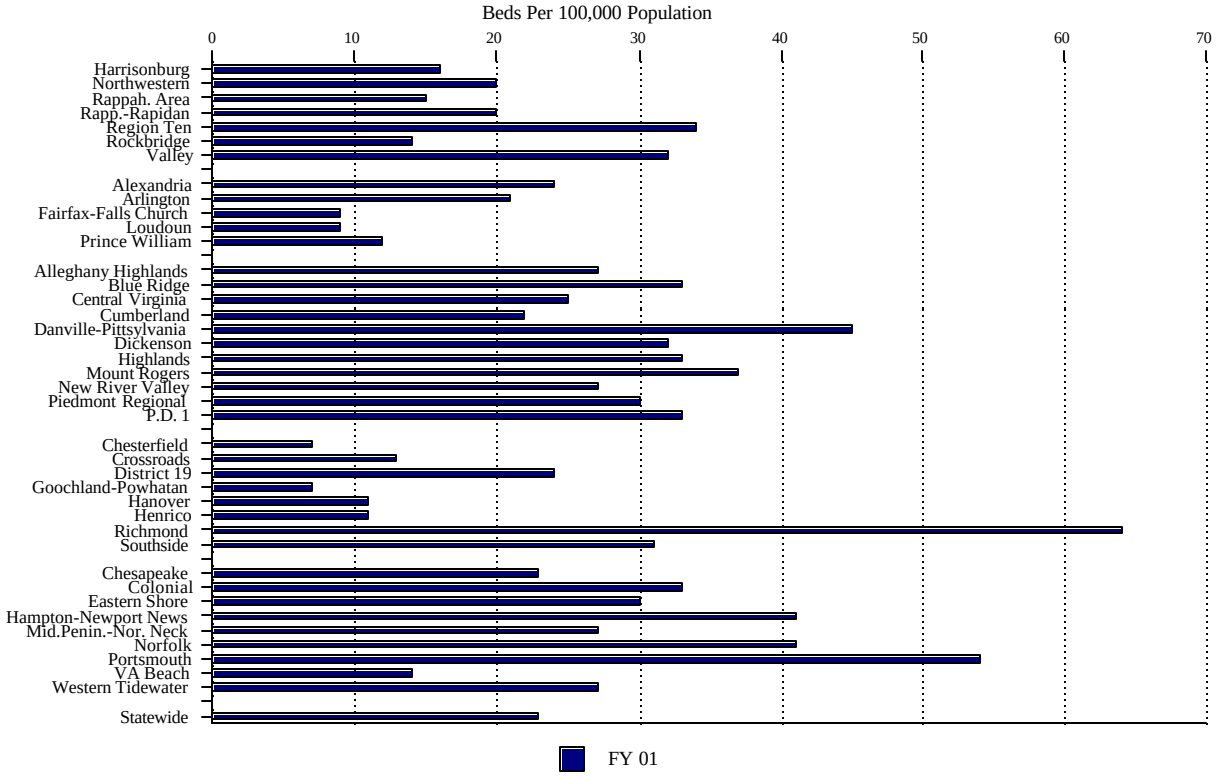
MH Facility	# Patients Served*	Average Daily Census	# Admissions	# Separations
Eastern State Hospital	1,460	493	1,148	1,115
Western State Hospital	971	258	767	780
Central State Hospital	739	289	510	481
Southwest VA MHI	872	153	898	890
Northern VA MHI	478	119	418	410
Southern VA MHI	357	72	340	331
Commonwealth Center for Children and Adolescents	414	37	432	436
Catawba Hospital	584	98	634	623
Piedmont Geriatric Hospital	199	123	76	73
Hiram Davis Medical Center	298	69	298	307
Total MH	6,372	1,710	5,521	5,483

State Mental Retardation Training Center Residents Served, Average Daily Census, Admissions, and Separations -- FY2001

MR Training Center	#Residents Served*	Average Daily Census	# Admissions	# Separations
Central Virginia TC	673	650	4	30
Northern Virginia TC	214	189	65	67
Southeastern Virginia TC	210	194	13	14
Southside Virginia TC	455	430	7	32
Southwestern Virginia TC	231	217	12	13
Total MR	1,783	1,680	101	156

Source: Patient Resident Automated Information System
* Unduplicated Count

Mental Health State Facility Utilization by CSB and Region -- FY 2001

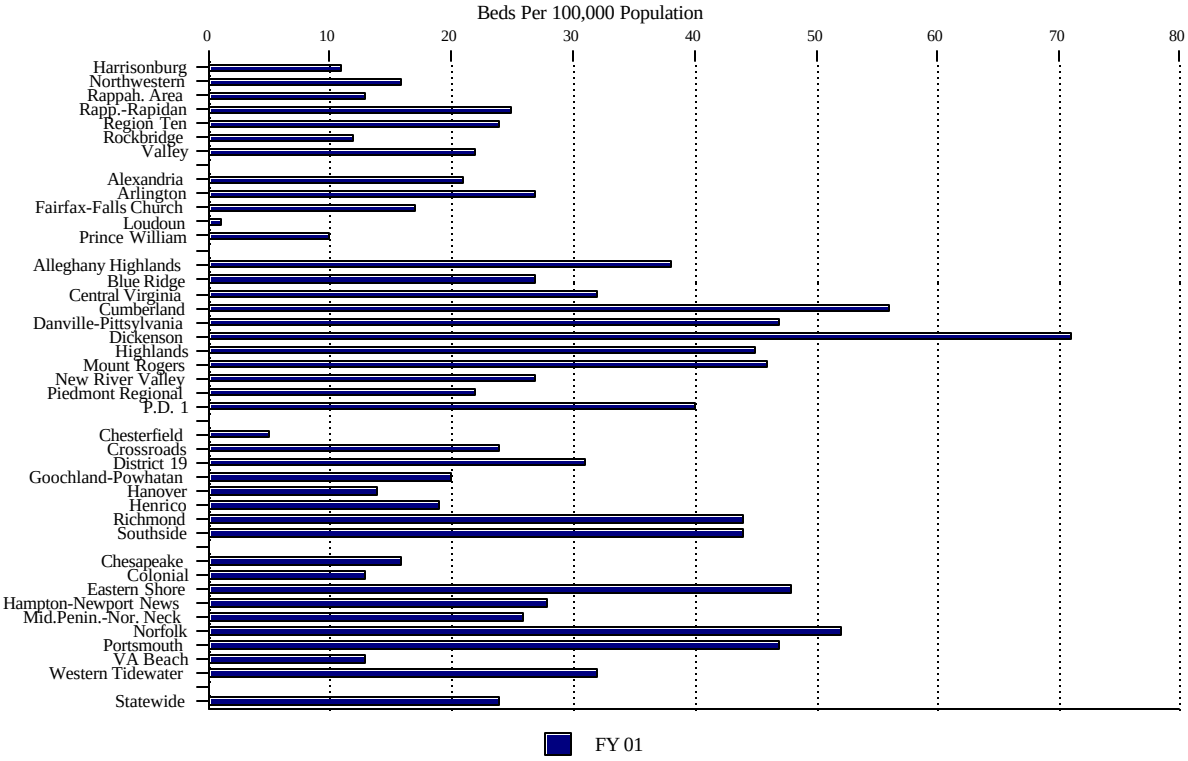


State Mental Health Facility Utilization by CSB and Region -- FY2001

	CSB	All Bed Days FY 2001	Population	FY 2001 Bed Days Per 100 K Population	FY 2001 Beds Per 100 K Population
I	Harrisonburg-Rockingham	6,438	108,193	5,950.48	16.30
	Northwestern	13,549	185,282	7,312.64	20.03
	Rappahannock Area	12,973	241,044	5,382.00	14.75
	Rappahannock-Rapidan	9,714	134,785	7,207.03	19.75
	Region Ten	24,903	199,648	12,473.45	34.17
	Rockbridge Area	1,946	39,072	4,980.55	13.65
	Valley	13,135	111,524	11,777.73	32.27
II	Alexandria	11,192	128,283	8,724.46	23.90
	Arlington	14,130	189,453	7,458.31	20.43
	Fairfax-Falls Church	33,520	1,001,624	3,346.57	9.17
	Loudoun County	5,466	169,599	3,222.90	8.83
	Prince William County	13,687	326,238	4,195.40	11.49
III	Alleghany Highlands	2,275	23,518	9,673.44	26.50
	Blue Ridge	28,573	241,023	11,854.89	32.48
	Central Virginia	20,376	228,616	8,912.76	24.42
	Cumberland Mountain	8,025	101,884	7,876.60	21.58
	Danville-Pittsylvania	17,926	110,156	16,273.29	44.58
	Dickenson County	1,926	16,395	11,747.48	32.18
	Highlands	8,167	68,470	11,927.85	32.68
	Mount Rogers	16,311	121,550	13,419.17	36.76
	New River Valley	16,084	165,146	9,739.26	26.68
	Piedmont	15,044	140,039	10,742.72	29.43
	Planning District 1	10,975	91,019	12,057.92	33.04
IV	Chesterfield	6,147	259,903	2,365.11	6.48
	Crossroads	4,745	97,103	4,886.56	13.39
	District 19	14,429	167,129	8,633.45	23.65
	Goochland-Powhatan	1,008	39,240	2,568.81	7.04
	Hanover County	3,306	86,320	3,829.94	10.49
	Henrico Area	11,255	282,688	3,981.42	10.91
	Richmond Behav. Health Auth.	46,161	197,790	23,338.39	63.94
	Southside	10,034	88,154	11,382.35	31.18
V	Chesapeake	16,501	199,184	8,284.30	22.70
	Colonial	15,596	127,963	12,187.90	33.39
	Eastern Shore	5,538	51,398	10,774.74	29.52
	Hampton-Newport News	48,787	326,587	14,938.44	40.93
	Middle Peninsula-Northern Neck	12,950	133,037	9,734.13	26.67
	Norfolk	34,951	234,403	14,910.65	40.85
	Portsmouth	19,676	100,565	19,565.46	53.60
	Virginia Beach	21,806	425,257	5,127.72	14.05
	Western Tidewater	11,906	119,233	9,985.49	27.36
	VIRGINIA STATEWIDE	591,131	7,078,515	8,463.67	23.19

Source: DMHMRSAS PRAIS System and 2000 Census

Mental Retardation Training Center by CSB and Region -- FY 2001



State Training Center Utilization by CSB and Region -- FY 2001

	CSB	All Bed Days FY 2001	Population	FY 2001 Bed Days Per 100 K Population	FY 2001 Beds Per 100 K Population
I	Harrisonburg-Rockingham	4,194	108,193	3,876.41	10.62
	Northwestern	10,562	185,282	5,700.50	15.62
	Rappahannock Area	11,028	241,044	4,575.10	12.53
	Rappahannock-Rapidan	12,292	134,785	9,119.71	24.99
	Region Ten	17,148	199,648	8,589.12	23.53
	Rockbridge Area	1,682	39,072	4,304.87	11.79
	Valley	9,071	111,524	8,133,68	22.28
II	Alexandria	9,833	128,283	7,665.08	21.00
	Arlington	18,962	189,453	10,008.81	27.42
	Fairfax-Falls Church	60,288	1,001,624	6,019.03	16.49
	Loudoun County	672	169,599	396.23	1.09
	Prince William County	12,031	326,238	3,687.80	10.10
III	Alleghany Highlands	3,282	23,518	13,955.27	38.23
	Blue Ridge	23,700	241,023	9,833,09	26.94
	Central Virginia	26,995	228,616	11,808.01	32.35
	Cumberland Mountain	20,698	101,884	20,315.26	55.66
	Danville-Pittsylvania	18,988	110,156	17,237.37	47.23
	Dickenson County	4,276	16,395	26,081.12	71.46
	Highlands	11,139	68,470	16,268.44	44.57
	Mount Rogers	20,606	121,550	16,952.69	46.45
	New River Valley	16,536	165,146	10,012.96	27.43
	Piedmont	11,257	140,039	8,038.47	22.02
	Planning District 1	13,258	91,019	14,566.19	39.91
IV	Chesterfield	4,295	259,903	1,652.54	4.53
	Crossroads	8,455	97,103	8,707.25	23.86
	District 19	18,889	167,129	11,302.05	30.96
	Goochland-Powhatan	2,886	39,240	7,354.74	20.15
	Hanover County	4,497	86,320	5,209.68	14.27
	Henrico Area	19,095	282,688	6,754.80	18.51
	Richmond Behav. Health Auth.	32,058	197,790	16,208.10	44.41
	Southside	14,114	88,154	16,010.62	43.86
V	Chesapeake	11,806	199,184	5,927.18	16.24
	Colonial	6,175	127,963	4,825.61	13.22
	Eastern Shore	9,069	51,398	17,644.66	48.34
	Hampton-Newport News	33,668	326,587	10,309.04	28.34
	Middle Peninsula-Northern Neck	12,823	133,037	9,638.67	26.41
	Norfolk	44,726	234,403	19.080.81	52.28
	Portsmouth	17,164	100,565	17,067.57	46.76
	Virginia Beach	20,580	425,257	4,839.43	13.26
	Western Tidewater	13,725	119,233	11,511.07	31.54
	VIRGINIA STATEWIDE	612,523	7,078,515	8,653.27	23.71

Source: DMHMRSAS PRAIS System and 2000 Census

State Mental Health and Mental Retardation Facility Numbers of Admissions, Separations and Average Daily Census
FY 1976 to FY 2001

	State Mental Health Facilities*			State Mental Retardation Training Centers**		
	Number of Admissions	Number of Separations	Average Daily Census	Number of Admissions	Number of Discharges	Average Daily Census
FY 1976	10,319	10,943	5,967	250	639	4,293
FY 1977	10,051	10,895	5,489	418	618	3,893
FY 1978	10,641	11,083	5,218	277	404	3,790
FY 1979	10,756	10,926	5,112	299	416	3,701
FY 1980	10,513	11,345	4,835	296	428	3,576
FY 1981	10,680	11,513	4,486	252	399	3,467
FY 1982	10,212	10,616	4,165	205	301	3,391
FY 1983	10,030	10,273	3,798	162	232	3,309
FY 1984	9,853	10,163	3,576	194	322	3,189
FY 1985	9,456	9,768	3,279	197	314	3,069
FY 1986	8,942	9,077	3,110	172	280	2,970
FY 1987	8,919	8,900	3,004	165	238	2,892
FY 1988	9,549	9,637	3,047	143	224	2,828
FY 1989	9,591	9,605	3,072	146	231	2,761
FY 1990	9,249	9,293	2,956	110	181	2,676
FY 1991	9,323	9,519	2,904	107	162	2,626
FY 1992	9,057	9,245	2,775	116	215	2,548
FY 1993	8,560	8,651	2,588	94	192	2,481
FY 1994	9,187	9,317	2,482	106	193	2,375
FY 1995	8,550	8,774	2,348	87	216	2,249
FY 1996	7,468	7,529	2,222	87	223	2,132
FY 1997	7,195	7,257	2,118	77	210	1,987
FY 1998	7,431	7,522	2,089	78	170	1,890
FY 1999	6,210	6,449	1,914	106	188	1,812
FY 2000	5,069	5,233	1,694	101	194	1,749
FY 2001	5,223	5,176	1,641	101	156	1,680

* Excludes Hiram Davis Medical Center. Includes the Virginia Treatment Center for Children (VTCC) through FY 91 when the VTCC was transferred to MCV.

** Operations at SVTC began in 1971, NVTC began in 1973, SWVTC in 1973, and SEVTC began in 1975.

Appendix D
Prevalence Estimates by CSB

Estimated Prevalence of Serious Mental Illness by CSB and Region

	CSB	Population Age 18 to 69 (2000 Census)	Estimated Adult SMI (4.9%)
I	Harrisonburg-Rockingham	72,542	3,555
	Northwestern	122,381	5,997
	Rappahannock Area	157,383	7,712
	Rappahannock-Rapidan	88,913	4,357
	Region Ten	135,211	6,625
	Rockbridge Area	26,120	1,280
	Valley	74,032	3,628
II	Alexandria	98,045	4,804
	Arlington	144,499	7,080
	Fairfax-Falls Church	695,009	34,055
	Loudoun County	113,075	5,541
	Prince William County	217,546	10,660
III	Alleghany Highlands	15,136	742
	Blue Ridge	158,447	7,764
	Central Virginia	150,274	7,363
	Cumberland Mountain	70,206	3,440
	Danville-Pittsylvania	71,395	3,498
	Dickenson County	11,070	542
	Highlands	45,948	2,251
	Mount Rogers	81,442	3,991
	New River Valley	115,779	5,673
	Piedmont	93,360	4,575
	Planning District 1	60,456	2,962
IV	Chesterfield	172,690	8,462
	Crossroads	63,547	3,114
	District 19	110,662	5,422
	Goochland-Powhatan	27,679	1,356
	Hanover County	56,769	2,782
	Henrico Area	188,132	9,218
	Richmond Behavioral Health Author.	132,907	6,512
	Southside	58,060	2,845
V	Chesapeake	129,964	6,368
	Colonial	84,388	4,135
	Eastern Shore	32,497	1,592
	Hampton-Newport News	216,082	10,588
	Middle Peninsula-Northern Neck	86,172	4,222
	Norfolk	155,879	7,638
	Portsmouth	64,116	3,142
	Virginia Beach	283,660	13,899
	Western Tidewater	77,481	3,797
	TOTAL	4,758,954	233,187

Estimated Prevalence of Child/Adolescent Serious Emotional Disturbance by CSB and Region

	CSB	Population Age 9-17 (2000 Census)	Estimated SED
I	Harrisonburg-Rockingham	14,573	1,312
	Northwestern	23,016	2,071
	Rappahannock Area	35,315	3,178
	Rappahannock-Rapidan	17,625	1,586
	Region Ten	24,951	2,246
	Rockbridge Area	4,813	433
	Valley	13,247	1,192
II	Alexandria	8,756	788
	Arlington	13,967	1,257
	Fairfax-Falls Church	121,765	10,959
	Loudoun County	21,010	1,891
	Prince William County	47,032	4,233
III	Alleghany Highlands	2,625	236
	Blue Ridge	27,801	2,502
	Central Virginia	28,737	2,586
	Cumberland Mountain	11,534	1,038
	Danville-Pittsylvania	13,287	1,196
	Dickenson	1,997	180
	Highlands	7,558	680
	Mount Rogers	13,220	1,190
	New River Valley	20,539	1,848
	Piedmont	16,299	1,467
	Planning District 1	10,755	968
IV	Chesterfield	38,446	3,460
	Crossroads	12,531	1,128
	District 19	21,249	1,912
	Goochland-Powhatan	4,602	414
	Hanover County	12,001	1,080
	Henrico Area	33,382	3,004
	Richmond Behavioral Health Authority	22,588	2,033
	Southside	10,090	908
V	Chesapeake	29,307	2,638
	Colonial	17,813	1,603
	Eastern Shore	6,384	575
	Hampton-Newport News	43,288	3,896
	Middle Peninsula-Northern Neck	15,931	1,434
	Norfolk	29,729	2,676
	Portsmouth	13,028	1,173
	Virginia Beach	58,597	5,274
	Western Tidewater	16,020	1,442
	TOTAL	885,408	79,687

Estimated Prevalence of Mental Retardation by CSB and Region

	CSB	Total 2000 Census	Estimated # Range Mild MR	Estimated # Moderate MR	Estimated # Severe MR	Estimated # Profound MR
I	Harrisonburg-Rockingham	108,193	400 - 638	216	141	43
	Northwestern	185,282	686 - 1,093	371	241	74
	Rappahannock Area	241,044	892 - 1,422	482	313	96
	Rappahannock-Rapidan	134,785	499 - 795	270	175	54
	Region Ten	199,648	739 - 1,178	399	260	80
	Rockbridge Area	39,072	145 - 231	78	51	16
	Valley	111,524	413 - 658	223	145	45
II	Alexandria	128,283	475 - 757	257	167	51
	Arlington	189,453	701 - 1,118	379	246	76
	Fairfax-Falls Church	1,001,624	3,706 - 5,910	2,003	1,302	401
	Loudoun County	169,599	628 - 1,001	339	220	68
	Prince William County	326,238	1,207 - 1,925	652	424	130
III	Alleghany Highlands	23,518	87 - 139	47	31	9
	Blue Ridge	241,023	892 - 1,422	482	313	96
	Central Virginia	228,616	846 -1,349	457	297	91
	Cumberland Mountain	101,884	377 - 601	204	132	41
	Danville-Pittsylvania	110,156	408 - 650	220	143	44
	Dickenson	16,395	61 - 97	33	21	7
	Highlands	68,470	253 - 404	137	89	27
	Mount Rogers	121,550	450 - 717	243	158	49
	New River Valley	165,146	611 - 974	330	215	66
	Piedmont	140,039	518 - 826	280	182	56
	Planning District 1	91,019	337 - 537	182	118	36
IV	Chesterfield	259,903	962 - 1,533	520	338	104
	Crossroads	97,103	359 -573	194	126	39
	District 19	167,129	618 - 986	334	217	67
	Goochland-Powhatan	39,240	145 - 232	78	51	16
	Hanover County	86,320	319 - 509	173	112	35
	Henrico Area	282,688	1,046 - 1,668	565	367	113
	Richmond BHA	197,790	732 - 1,167	396	257	79
	Southside	88,154	326 - 520	176	115	35
V	Chesapeake	199,184	737 - 1,175	398	259	80
	Colonial	127,963	473 - 755	256	166	51
	Eastern Shore	51,398	190 - 303	103	67	21
	Hampton-Newport News	326,587	1,208 - 1,927	653	425	131
	Middle Peninsula-Northern Neck	133,037	492 - 785	266	173	53
	Norfolk	234,403	867 - 1,383	469	305	94
	Portsmouth	100,565	372 - 593	201	131	40
	Virginia Beach	425,257	1,573 - 2,509	851	553	170
	Western Tidewater	119,233	441 - 703	238	155	48
	TOTAL	7,078,515	26,191 - 41,763	14,155	9,201	2,832

Estimated Prevalence of Substance Dependence by CSB and Region

	CSB	Population 10+ 2000 Census	Estimated # Drug Dependence (1.6%)	Estimated # Alcohol Dependence (3.7%)	Estimated # Drug & Alcohol Depend.
I	Harrisonburg-Rockingham	95,636	1,530	3,539	5,069
	Northwestern	161,008	2,576	5,957	8,533
	Rappahannock Area	202,945	3,247	7,509	10,756
	Rappahannock-Rapidan	116,910	1,871	4,326	6,196
	Region Ten	175,276	2,804	6,485	9,290
	Rockbridge Area	35,007	560	1,295	1,855
	Valley	98,045	1,569	3,628	5,196
II	Alexandria	114,368	1,830	4,232	6,062
	Arlington	170,315	2,725	6,302	9,027
	Fairfax-Falls Church	860,020	13,760	31,821	45,581
	Loudoun County	137,869	2,206	5,101	7,307
	Prince William County	269,767	4,316	9,981	14,298
III	Alleghany Highlands	20,689	331	765	1,097
	Blue Ridge	211,377	3,382	7,821	11,203
	Central Virginia	200,153	3,202	7,406	10,608
	Cumberland Mountain	90,596	1,450	3,352	4,802
	Danville-Pittsylvania	96,806	1,549	3,582	5,131
	Dickenson County	14,575	233	539	772
	Highlands	61,002	976	2,257	3,233
	Mount Rogers	107,753	1,724	3,987	5,711
	New River Valley	148,550	2,377	5,496	7,873
	Piedmont	123,649	1,978	4,575	6,553
	Planning District 1	80,318	1,285	2,972	4,257
IV	Chesterfield	221,753	3,548	8,205	11,753
	Crossroads	85,790	1,373	3,174	4,547
	District 19	145,813	2,333	5,395	7,728
	Goochland-Powhatan	34,545	553	1,278	1,831
	Hanover County	73,969	1,184	2,737	3,920
	Henrico Area	243,449	3,895	9,008	12,903
	Richmond BHA	172,649	2,762	6,388	9,150
	Southside	77,834	1,245	2,880	4,125
V	Chesapeake	168,774	2,700	6,245	8,945
	Colonial	111,730	1,788	4,134	5,922
	Eastern Shore	44,837	717	1,659	2,376
	Hampton-Newport News	278,640	4,458	10,310	14,768
	Middle Peninsula-Nor. Neck	117,887	1,886	4,362	6,248
	Norfolk	201,349	3,222	7,450	10,671
	Portsmouth	86,100	1,378	3,186	4,563
	Virginia Beach	361,118	5,778	13,361	19,139
	Western Tidewater	102,578	1,641	3,795	5,437
	TOTAL	6,121,449	97,942	226,495	324,436

Appendix E
Individuals on Waiting Lists for CSB Services by CSB

Numbers of Adults on CSB Mental Health Services Waiting Lists on April 2, 2001

	CSB	Est. Prevalence Adult SMI 2000 Census	Unduplicated Numbers from FY 2000 4th Quarter Rept # Served	# SMI	On CSB Waiting List Not Receiving CSB Services	Receiving Some CSB Services	Total on CSB Waiting List
I	Harrisonburg-Rockingham	3,555	1,369	609	5	48	53
	Northwestern	5,997	2,155	920	4	61	65
	Rappahannock Area	7,712	2,333	1,299	0	4	4
	Rappahannock-Rapidan	4,357	2,524	622	2	66	68
	Region Ten	6,625	1,933	515	25	33	58
	Rockbridge	1,280	908	233	5	0	5
	Valley	3,628	1,481	577	0	0	0
II	Alexandria	4,804	1,797	657	19	91	110
	Arlington	7,080	1,788	1,109	1	67	68
	Fairfax-Falls Church	34,055	9,854	4,768	180	688	868
	Loudoun	5,541	1,666	444	10	22	32
	Prince William	10,660	2,520	710	22	120	142
III	Alleghany-Highlands	742	597	157	0	11	11
	Blue Ridge	7,764	4,410	2,774	0	46	46
	Central Virginia	7,363	3,927	3,045	0	0	0
	Cumberland Mountain	3,440	1,850	541	0	200	200
	Danville-Pittsylvania	3,498	1,255	461	22	28	50
	Dickenson County	542	512	459	0	0	0
	Highlands	2,251	1,723	736	0	98	98
	Mount Rogers	3,991	2,486	1,938	24	633	657
	New River Valley	5,673	2,201	642	19	57	76
	Piedmont Regional	4,575	1,988	1,052	16	116	132
	P.D. 1	2,962	2,141	1,223	0	24	24
IV	Chesterfield	8,462	1,427	527	26	77	103
	Crossroads	3,114	1,518	621	12	66	78
	District 19	5,422	2,141	1,008	3	135	138
	Goochland-Powhatan	1,356	354	127	1	24	25
	Hanover	2,782	1,744	327	11	74	85
	Henrico	9,218	2,440	990	7	270	277
	Richmond BHA	6,512	5,341	2,319	17	69	86
	Southside	2,845	1,309	805	3	14	17
V	Chesapeake	6,368	1,367	548	0	22	22
	Colonial	4,135	1,535	197	48	19	67
	Eastern Shore	1,592	1,218	346	1	11	12
	Hampton-Newport News	10,588	5,098	3,312	25	116	141
	Middle Pen.-Northern Neck	4,222	2,252	629	58	37	95
	Norfolk	7,638	4,044	1,636	0	75	75
	Portsmouth	3,142	1,230	839	4	9	13
	Virginia Beach	13,899	1,965	1,339	7	278	285
	Western Tidewater	3,797	1,522	615	16	156	172
	TOTAL	233,187	89,923	41,676	593	3,865	4,458

Numbers of Children and Adolescents on CSB Mental Health Services Waiting Lists on April 2, 2001

	CSB	Est. Prevalence SED 2000 Census	Unduplicated Numbers from FY 2000 4th Quarter Rept # Served	# SED	On CSB Waiting List Not Receiving CSB Services	Receiving Some CSB Services	Total on CSB Waiting List
I	Harrisonburg-Rockingham	1,312	427	213	0	7	7
	Northwestern	2,071	760	439	0	6	6
	Rappahannock Area	3,178	889	639	0	0	0
	Rappahannock-Rapidan	1,586	736	263	0	20	20
	Region Ten	2,246	674	327	11	1	12
	Rockbridge	433	305	178	4	0	4
	Valley	1,192	379	96	0	1	1
II	Alexandria	788	406	210	3	15	18
	Arlington	1,257	76	36	19	5	24
	Fairfax-Falls Church	10,959	1,815	659	45	44	89
	Loudoun	1,891	532	208	12	10	22
	Prince William	4,233	832	122	7	4	11
III	Alleghany-Highlands	236	146	17	0	0	0
	Blue Ridge	2,502	1,096	655	1	32	33
	Cumberland Mountain	1,038	325	83	0	66	66
	Danville-Pittsylvania	1,196	223	65	27	4	31
	Dickenson County	180	132	120	0	0	0
	Highlands	680	565	253	4	18	22
	Mount Rogers	1,190	527	338	4	109	113
	New River Valley	1,848	638	172	3	23	26
	Piedmont Regional	1,467	852	516	8	221	229
	P.D. 1	968	701	440	0	0	0
IV	Chesterfield	3,460	459	174	19	45	64
	Crossroads	1,128	528	218	4	10	14
	District 19	1,912	620	186	9	35	44
	Goochland-Powhatan	414	259	6	1	7	8
	Hanover	1,080	520	171	2	63	65
	Henrico	3,004	857	363	4	57	61
	Richmond BHA	2,033	1,398	643	4	33	37
	Southside	908	396	190	5	4	9
V	Chesapeake	2,638	543	144	0	14	14
	Colonial	1,603	368	53	19	0	19
	Eastern Shore	575	593	234	0	52	52
	Hampton-Newport News	3,896	1,619	1,191	43	20	63
	Middle Pen.-Northern Neck	1,434	519	180	36	16	52
	Norfolk	2,676	406	159	0	0	0
	Portsmouth	1,173	396	179	1	10	11
	Virginia Beach	5,274	503	455	3	9	12
	Western Tidewater	1,442	386	287	11	46	57
	TOTAL	79,687	25,309	12,411	312	1,037	1,349

Numbers of Adults on CSB Mental Retardation Services Waiting Lists on April 2, 2001

	CSB	Est. MR Prevalence (Mild, Moderate, Severe and Profound) 2000 Census	Unduplicated # Served FY 2000 4th Quarter Rept	On CSB Waiting List Not Receiving CSB Services	On CSB Waiting List Receiving Some CSB Services	Total on CSB Waiting List
I	Harrisonburg-Rockingham	801 - 1,039	260	0	90	90
	Northwestern	1,371 - 1,779	668	22	75	97
	Rappahannock Area	1,784 - 2,314	655	2	96	98
	Rappahannock-Rapidan	997 - 1,294	238	1	75	76
	Region Ten	1,477 - 1,917	258	46	73	119
	Rockbridge	289 - 375	194	0	38	38
	Valley	825 - 1,071	456	61	89	150
II	Alexandria	949 - 1,232	397	8	18	26
	Arlington	1,401 - 1,819	182	3	30	33
	Fairfax-Falls Church	7,412 - 9,616	1,691	282	326	608
	Loudoun	1,255 - 1,628	371	64	42	106
	Prince William	2,414 - 3,132	688	24	162	186
III	Alleghany-Highlands	174 - 226	210	5	17	22
	Blue Ridge	1,784 - 2,314	607	8	172	180
	Central Virginia	1,692 - 2,195	981	74	3	77
	Cumberland Mountain	754 - 978	221	4	36	40
	Danville-Pittsylvania	815 - 1,057	561	9	74	83
	Dickenson County	121 - 157	59	0	0	0
	Highlands	507 - 657	256	2	19	21
	Mount Rogers	899 - 1,167	362	14	130	144
	New River Valley	1,222 - 1,585	223	0	6	6
	Piedmont Regional	1,036 - 1,344	249	11	41	52
	P.D. 1	674 - 874	311	3	20	23
IV	Chesterfield	1,923 - 2,495	931	1	552	553
	Crossroads	719 - 932	197	15	13	28
	District 19	1,237 - 1,604	833	60	64	124
	Goochland-Powhatan	290 - 377	127	2	12	14
	Hanover	639 - 829	196	1	90	91
	Henrico	2,092 - 2,714	820	0	143	143
	Richmond Behavioral	1,464 - 1,899	1,051	1	235	236
	Southside	652 - 846	191	4	27	31
V	Chesapeake	1,474 - 1,912	524	37	47	84
	Colonial	947 - 1,228	210	0	4	4
	Eastern Shore	380 - 493	339	35	24	59
	Hampton-Newport News	2,417 - 3,135	873	15	92	107
	Middle Pen.-Northern Neck	984 - 1,277	410	11	15	26
	Norfolk	1,735 - 2,250	609	16	86	102
	Portsmouth	744 - 965	324	14	52	66
	Virginia Beach	3,147 - 4,082	903	35	130	165
	Western Tidewater	882 - 1,145	290	2	106	108
	TOTAL	52,381 - 67,954	18,926	892	3,324	4,216

Numbers of Adults on CSB Substance Abuse Services Waiting Lists on April 2, 2001

	CSB	Est. Prevalence of Drug & Alcohol Dependence (Ages 10+) 2000 Census	Unduplicated # Served FY 2000 4th Quarter Rept	On CSB Waiting List Not Receiving CSB Services	On CSB Waiting List Receiving Some CSB Services	Total on CSB Waiting List
I	Harrisonburg-Rockingham	5,069	568	2	10	12
	Northwestern	8,533	849	6	2	8
	Rappahannock Area	10,756	1,944	0	0	0
	Rappahannock-Rapidan	6,196	1,203	1	19	20
	Region Ten	9,290	1,555	9	10	19
	Rockbridge	1,855	362	11	2	13
	Valley	5,196	909	0	0	0
II	Alexandria	6,062	1,801	4	16	20
	Arlington	9,027	1,227	5	27	32
	Fairfax-Falls Church	45,581	5,172	209	584	793
	Loudoun	7,307	1,015	0	17	17
	Prince William	14,298	2,276	0	5	5
III	Alleghany-Highlands	1,097	232	0	0	0
	Blue Ridge	11,203	1,490	1	41	42
	Central Virginia	10,608	1,322	0	0	0
	Cumberland Mountain	4,802	1,329	1	166	167
	Danville-Pittsylvania	5,131	847	11	92	103
	Dickenson County	772	224	0	0	0
	Highlands	3,233	863	3	29	32
	Mount Rogers	5,711	728	15	69	84
	New River Valley	7,873	1,109	15	20	35
	Piedmont Regional	6,553	1,256	6	21	27
	P.D. 1	4,257	969	8	11	19
IV	Chesterfield	11,753	1,127	45	66	111
	Crossroads	4,547	491	20	6	26
	District 19	7,728	3,200	34	74	108
	Goochland-Powhatan	1,831	277	2	9	11
	Hanover	3,920	690	1	17	18
	Henrico	12,903	1,670	18	52	70
	Richmond Behavioral	9,150	3,932	2	123	125
	Southside	4,125	448	0	0	0
V	Chesapeake	8,945	1,148	0	3	3
	Colonial	5,922	901	52	19	71
	Eastern Shore	2,376	437	0	4	4
	Hampton-Newport News	14,768	3,138	8	29	37
	Middle Pen.-Northern Neck	6,248	1,442	3	19	22
	Norfolk	10,671	3,008	14	34	48
	Portsmouth	4,563	1,502	42	2	44
	Virginia Beach	19,139	2,236	19	10	29
	Western Tidewater	5,437	1,068	2	9	11
	TOTAL	324,436	55,965	569	1,617	2,186

Numbers of Adolescents on CSB Substance Abuse Services Waiting Lists on April 2, 2001

	CSB	Est. Prevalence of Drug & Alcohol Dependence (Ages 10+) 2000 Census	Unduplicated # Served FY 2000 4th Quarter Rept	On CSB Waiting List		Total on CSB Waiting List
				Not Receiving CSB Services	Receiving Some CSB Services	
I	Harrisonburg-Rockingham	5,069	31	0	0	0
	Northwestern	8,533	72	0	1	1
	Rappahannock Area	10,756	452	0	0	0
	Rappahannock-Rapidan	6,197	85	0	1	1
	Region Ten	9,289	136	0	0	0
	Rockbridge	1,855	27	0	0	0
	Valley	5,197	98	0	0	0
II	Alexandria	6,062	237	0	3	3
	Arlington	9,027	34	7	0	7
	Fairfax-Falls Church	45,581	991	21	60	81
	Loudoun	7,307	501	0	9	9
	Prince William	14,297	843	0	0	0
III	Alleghany-Highlands	1,096	22	0	0	0
	Blue Ridge	11,203	176	1	7	8
	Central Virginia	10,608	142	0	0	0
	Cumberland Mountain	4,802	400	0	14	14
	Danville-Pittsylvania	5,131	167	11	7	18
	Dickenson County	0	13	0	0	0
	Highlands	3,233	400	0	16	16
	Mount Rogers	5,711	57	0	40	40
	New River Valley	7,873	169	0	0	0
	Piedmont Regional	6,553	184	1	44	45
	P.D. 1	4,257	66	0	0	0
IV	Chesterfield	11,753	190	0	10	10
	Crossroads	4,547	34	0	4	4
	District 19	7,728	354	0	0	0
	Goochland-Powhatan	1,831	29	0	0	0
	Hanover	3,921	163	0	14	14
	Henrico	12,903	293	1	13	14
	Richmond Behavioral	9,150	335	0	21	21
	Southside	4,125	30	0	0	0
V	Chesapeake	8,945	194	0	0	0
	Colonial	5,922	152	7	12	19
	Eastern Shore	2,376	41	0	0	0
	Hampton-Newport News	14,768	1,219	8	3	11
	Middle Pen.-Northern Neck	6,248	123	2	0	2
	Norfolk	10,672	263	0	0	0
	Portsmouth	4,564	68	0	0	0
	Virginia Beach	19,139	176	6	1	7
	Western Tidewater	5,436	32	0	0	0
	TOTAL	324,437	8,999	65	280	345

Appendix F
State Facility Patients and Residents on Ready for Discharge Lists by CSB

Number of Individuals on Ready for Discharge Lists on June 30, 2001

		Number Ready for Discharge from State MH Facility	Number Choosing Training Center Discharge for Community Services	Total Number on Discharge Lists
I	Harrisonburg-Rockingham	0	2	2
	Northwestern	0	8	8
	Rappahannock Area	1	4	5
	Rappahannock-Rapidan	2	8	`0
	Region Ten	1	8	9
	Rockbridge	0	3	3
	Valley	5	8	13
II	Alexandria	0	3	3
	Arlington	1	12	13
	Fairfax-Falls Church	11	26	37
	Loudoun	2	0	2
	Prince William	4	0	4
III	Alleghany-Highlands	0	0	0
	Blue Ridge	19	20	39
	Central Virginia	8	5	13
	Cumberland Mountain	0	2	2
	Danville-Pittsylvania	4	11	15
	Dickenson County	1	1	2
	Highlands	0	2	2
	Mount Rogers	1	1	2
	New River Valley	2	0	2
	Piedmont Regional	6	4	10
	P.D. 1	0	0	0
IV	Chesterfield	1	0	1
	Crossroads	4	1	5
	District 19	11	12	23
	Goochland-Powhatan	0	3	3
	Hanover	0	0	0
	Henrico	2	17	19
	Richmond Behavioral	18	24	42
	Southside	4	5	9
V	Chesapeake	6	4	10
	Colonial	3	1	4
	Eastern Shore	0	4	4
	Hampton-Newport News	7	17	24
	Middle Pen.-Northern Neck	1	6	7
	Norfolk	0	18	18
	Portsmouth	8	5	13
	Virginia Beach	4	6	10
	Western Tidewater	0	5	5
	TOTAL	137	256	393

Appendix G
Proposed State Facility Capital Priority Listing 2002-2008

Item	Project Type	Proposed Funds	Notes
2002-2004 Biennium Maintenance Reserve		$1,607,800	
Life Safety Code Compliance, Phase 2	Improvement	6,522,000	
Boilers, Steamlines, HVAC, Phase 5	Improvement	11,368,000	SEVTC and SWVTC hot water distribution
Asbestos/Environmental Hazard Abatement	Improvement	2,196,000	
Food Service Modifications, Phase 2	Improvement	2,629,540	
Repair/Replace Site Utilities, Phase 1	Improvement	2,348,000	Water, sewer, and storm water systems at WSH, SVTC, CVTC, CH, SEVTC, and chilled water at NVTC
ADA and Site Access Improvement, Phase 2	Improvement	3,600,000	Paving, sidewalks, ramps, curbs at WSH, NVTC, SVTC
Relocate Hancock Geriatric Center, ESH	Improvement	9,629,442	
Renovations and Addition to Bldg. 4 and Renovations to Bldg. 1, NVTC	Improvement	10,562,315	
Cottage Replacement. Phase 1, SEVTC	New Construction	4,656,000	
Renovate Building 43, CSH	Improvement	4,873,000	Allow vacation of Bldg. 113
Planning for Client Activity Center, SVTC	New Construction	627,000	Allow vacation of North Campus
Renovations of Bldgs. 112 and 117, WSH	Improvement	12,816,777	
Environment of Care Building, SVTC	New Construction	4,670,000	B & G, security, transportation
Renovate Building 95, CSH	Improvement	5,480,000	
Planning for Renovation of PGH, Phase 2	Improvement	794,710	
Planning for Cottage Replacement, SWVTC	New Construction	939,000	
Demolition of Abandoned Buildings, Phase 1	Improvement	3,936,000	
TOTAL 2002-2004 Capital Request		$89,255,584	
2004-2006 Biennium Maintenance Reserve	Improvement	1,848,000	
Life Safety Code Compliance, Phase 3	Improvement	8,103,000	
Asbestos/Environmental Hazard Abatement	Improvement	1,673,000	
Boilers, Steam Lines, HVAC, Phase 6	Improvement	7,386,000	
Food Service Modifications, Phase 3	Improvement	8,108,500	
Repair/Replace Site Utilities, Phase 2	Improvement	1,954,000	
ADA and Site Access Improvement, Phase 2	Improvement	310,000	

Item	Project Type	Proposed Funds	Notes
Cottage Replacement, Phase 2, SEVTC	New Construction	4,786,000	
Renovation of Cottages, Phase 1, NVTC	Improvement	4,918,313	Cottage 3
Construct Client Activity Center, SVTC	New Construction	6,958,000	
Renovate PGH, Phase 2	New Construction	14,445,151	
Renovate Building 122, WSH	Improvement	9,136,126	
Renovate Cottages, Phase 1, SWVTC	Improvement	6,372,000	
Renovate Buildings 15 and 16, CVTC	Improvement	8,160,000	
Renovate Building 94, CSH	Improvement	5,854,000	
Demolition of Abandoned Buildings, Phase 2	Improvement	2,672,000	
TOTAL 2004-2006 Capital Request		$84,575,590	
2006-2008 Biennium			
Life Safety Code Compliance, Phase 4	Improvement	8,361,000	
Boilers, Steamlines, HVAC, Phase 7	Improvement	10,592,000	
Food Service Modifications, Phase 4	Improvement	9,113,300	
Repair/Replace Site Utilities, Phase 3	Improvement	1,870,000	
ADA and Site Access Improvement, Phase 3	Improvement	1,072,000	
Cottage Replacement, Phase 3, SEVTC	New Construction	5,039,000	Final phase
Renovation of Cottages, Phase 2, NVTC	Improvement	5,459,670	Cottages 5 and 6
Renovate Cottages, Phase 2, SWVTC	Improvement	3,485,000	
Renovate Buildings 113 and 116, WSH	Improvement	14,007,590	
Renovate Building 93, CSH	Improvement	6,288,000	
Renovate Buildings 17 and 18, CVTC	Improvement	8,263,000	
Construct Patient Activities Bldg., CSH	New Construction	3,137,000	
Planning for Renovations to NVMHI	New Construction	13,790,000	Renovate front, construct parking and administration areas
Demolition of Abandoned Buildings, Phase 3	Improvement	2,461,000	
TOTAL 2004-2006 Capital Request		$92,938,560	

DMHMRSAS Budget Initiative for Facility Energy Costs

New Motors The Department has replaced large motors that required heavy electrical loads and extremely large energy amounts to start with variable speed motors that can come up to speed without the intense electrical usage.

Re-lamping The facilities have removed old two and four tube florescent light fixtures and ballasts and replaced them with T8 fixtures. These fixtures use significantly less power and provide a better light.

Boiler Replacements The Department's boilers were all approximately 40 years old and grandfathered as to pollution controls and air emissions. Most were coal burning and required staffing around the clock, seven days a week. All but one plant has been converted to gas, gas/oil, or oil burning boilers with high efficiency ratings. Updated plants can be monitored by a modem and run by an energy maintenance management software program monitored from one source, eliminating plant staffing.

Chiller Replacement Most facility air-conditioned buildings were air conditioned over twenty years ago. The Department is replacing these old inefficient chillers for more efficient systems as fast as financially possible.

Steam line Repair The Department has begun a repair, replacement, and asbestos removal or abatement project to replace old and leaking steam lines, traps, valves, and condensate return lines. This effort is providing more than ample steam with less demand on the new boilers. It is also receiving the hot condensate return at a higher rate, which means that the boilers need less water and chemicals for water treatment.

Trap Maintenance Plan Associated with the steam line repairs, condensate return, and the removal or abatement of asbestos within the tunnels, the Department can now have a trap testing and maintenance plan. This will allow for traps to be removed or repaired instead of allowing the steam to blow by.

Window Air Conditioning The Department is slowly improving the structures that are now being cooled with window air conditioners by installing central air systems. Window air conditioners are heavy energy users.

Ice Storage The Department is making and storing ice at night when the cost of electricity is the lowest. This ice is used to cool the facility during the day. This reduces the electrical load from chillers during the day, thereby saving expensive daytime energy.

Duct Cleaning and Insulation Where the Department has repaired or replaced air conditioning ducts, it is cleaning the duct system and repairing the insulation. This makes for cleaner air and allows the air to circulate freely from the duct system, requiring less air to cool the area.

Energy Maintenance Management Systems With every new or renovated heating or air conditioning system, the Department is installing a digital monitoring system connected to a PC and operated by a software system. This system monitors room conditions and generates an alarm when there are problems with the equipment. It locates the problem, so that a work order can be printed.

Commissioning Since the directive to save energy, the Department has contracted with a commissioning engineering firm to come in at the completion of any project involving heating or air conditioning and "commissions" the project. Control engineers operate every fan and motor to verify that the project operates exactly as designed. This is intended to prevent problems after the general contractor has completed work. By starting with a verified system, the Department saves time, money and energy.

PACRAT Software "Pacrat" is a new software program designed by the Departments' commissioning engineer. It is the first program in the nation to analyze and evaluate information created by the energy management system. Once a month *Pacrat* will to create and print a report explaining whether the system is still operating as designed. If an anomaly is discovered, the program will explain the reason for the anomaly and how it can be corrected. This system is in the "pilot" stage at two facilities. It will be funded by a grant from Virginia Power and run by DMME.

MP-2 MP-2 is a computerized maintenance management system that will create daily work orders for each trade once it is fully installed at each facility. Through the use of this management tool, filters get changed on time and repairs are made, all of which save the Department energy and operating funds.

Steam Pressure Reductions As the census of state facilities has been reduced, the Department has been able to

close buildings, thereby reducing demands for steam. Steam pressure requirements should be sufficient to convert steam to hot water in each building. Reductions in steam pressure allow for fuel savings thus saving energy.

Closing Buildings Closing buildings by completely removing all furniture and equipment, draining the plumbing including the sprinkler systems, and shutting off water, electricity, and steam has results in energy savings.

New Generators The Department has installed some standby emergency power generators. Previously, a number of facilities with sufficient generator capacity to meet the standard required by Virginia Power entered into a SGVA contract that enabled the facility to run its generators and take certain buildings off-line when the utility needed power. For this, the facility received a monthly check. Now facilities use their generators on hot days to prevent peaking on electricity. This power shaving keeps the amount that the facility pays per kilowatt lower all year.

Reinsulation of piping In the past, insulation for chilled and hot water was allowed to fall off or remain in a damaged condition because the insulation contained high concentrations of asbestos fibers. With asbestos abatement funds, the Department removed this material and properly reinsulated the piping, thereby saving energy.

Replacement of Refrigeration Equipment Walk-in refrigerators and freezers boxes at the facilities were installed when the food service buildings were built. Many of the electric motors and compressors were 30 to 40 years old and were high-energy users and high maintenance. The worst of these units have been replaced with new units with better insulation and energy saving motors and compressors. However, older equipment at almost all facility food service kitchens need replacement.

Golf Carts Where feasible the facilities are replacing pick up trucks with golf carts for maintenance, food deliveries, mail deliveries, and general maintenance travel around the facility. With trailers and covered cabs, these small motored carts are saving on the high maintenance of trucks and fuel.

Cooling Tower Replacement With age, cooling towers decline in their ability to cool water used to create some air conditioning. Also the cooling tower vanes were often constructed of asbestos. With asbestos abatement funds, the Department is replacing some of these towers with new and more efficient towers, thus saving energy.

Windows and Doors Many older facilities were constructed with steel casement windows and single strength glass that has no insulation value. Windows in some of these facilities have been replaced with aluminum thermal break frames, with tempered double insulated glass. The Department is also replacing poorly constructed and uninsulated exterior doors. Recently constructed facilities have these energy saving features.

Gas Brokerage Five years ago, the Department began to purchase gas at the well head through a gas broker. The Department of Corrections, Community Colleges, universities, and cities and towns have subsequently joined the Department's contract to allow even larger reductions in the cost of gas. This project has saved the Department and the Commonwealth millions of dollars.

Electrical Metering and Real Time Monitoring This "pilot project" will become a requirement when deregulation of electricity becomes a reality. This is not an energy saving means but it will allow for energy use monitoring.

Electrical Contract In 1998 and 1999, the Department joined with the Department of Mines Minerals and Energy in negotiating a five-year kilowatt hour frozen rate with Virginia Power. This contract will extend through the first few years of deregulation, allowing the Department to become knowledgeable about negotiations for deregulated electricity.

Roof Insulation This Department is mandated to use its maintenance reserve monies first to repair or replace leaking roofs. As each roof is repaired or replaced, a new layer of rigid insulation is installed. The Department is using more EPDM rubber roofs on structures. This is a good roof for less money. To protect the black rubber from the sun, the Department is applying a white hypalon coating to reflect the sun and maintains a cooler "attic" area.

Ozone Laundries By using ozone in the laundry water, the Department has been able to reduce water temperatures, needed chemicals, water/sewer, and power plant steam load. All of these reductions amount to approximately a 45% savings in non-labor operating cost to the facilities. An unexpected savings was the extended life of the flatware linens because the reduced bleach no longer breaks down the linen fibers. Additionally, one facility's laundry has water recycling equipment that will save more energy.

Appendix H
Terrorism-Related Mental Service and Infrastructure Resource Requirements

Mental Health and Substance Abuse Service and Infrastructure Enhancements Proposed in Virginia Terrorism-Related Mental Health Needs Assessment submitted by the Department to the U.S. Department of Health and Human Services on November 26, 2001

Title	Proposed Response/Outcome	Required Funds Annualized MH	SA	Total
SPIRIT Implementation	Operational costs for 4 teams	4,000,000		4,000,000
Residential Crisis Stabilization	Five 8-bed regional programs	3,361,680		3,361,680
Emergency Services	36 FTEs in addition to those requested by four Northern Virginia CSBs	3,026,025		3,026,025
Outpatient Mental Health Services	44 treatment FTEs in addition to those requested by four Northern Virginia CSBs	4,137,232		4,137,232
MH Case Management Services	38 case managers in addition to those requested by two Northern Virginia CSBs	2,794,634		2,794,634
SA Case Management Services	40 case managers, one per CSB		2,941,720	2,941,720
CISM Targeted Follow-Up	18 CISM clinical staff in addition to those requested by two Northern Virginia CSBs	1,692,504		1,692,504
Media and Public Service Announcements	Campaign modeled after Oklahoma City experience (24 months post disaster)	500,000		500,000
Behavioral Consultation Services	Expand to meet the needs of individuals with mental retardation	600,000		600,000
Psychiatric Services	22,767 hours across the 40 CSBs in addition to those requested by two Northern Virginia CSBs	3,794,500		3,794,500

Title	Proposed Response/Outcome	Required Funds Annualized MH	SA	Total
Substance Abuse Outpatient Services	46 clinical FTEs in addition to those requested by two Northern Virginia CSBs		3,623,974	3,623,974
SA Diversion From Emergency Rooms	1,360 individuals in addition to that requested by one Northern Virginia CSB		1,702,040	1,702,040
In-Home Services for Children, Adolescents, and Families	1 FTE at 24 CSBs (in addition to that requested by one Northern Virginia CSB) and 4 FTE in-home teams at 15 CSBs	3,132,210	3,072,491	6,204,701
Increased PACT Capacity	1 FTE SA specialist at 15 existing PACT teams		1,181,730	1,181,730
Specialized Assertive Community Treatment for MI/SA Consumers	2 specialized assertive treatment teams for MI/SA consumers		1,700,000	1,700,000
Residential and Respite Services for Children, Adolescents, and Families	Expand residential and respite services to serve an additional 200 children or adolescents	1,000,000		1,000,000
Mental Health Tertiary Prevention Services (New Mission)	38 FTEs in addition to those requested by two Northern Virginia CSBs	2,854,522		2,854,522
Substance Abuse Prevention Services	46 FTEs in addition to those requested by two Northern Virginia CSBs		3,455,474	3,455,474
Training of Response Professionals and Registry	Targeted training for MH and SA professionals and new centralized registry of trained professionals [The Department received $150,000 for training from SAMHSA.]	112,500	112,500	225,000
Prevention Training and Technical Assistance	University-based prevention center for training and technical assistance		500,000	500,000
Disaster Preparedness and Recovery Planning and Coordination	1 full-time disaster coordinator position in the Department plus support costs	100,000		100,000

Title	Proposed Response/Outcome	Required Funds Annualized MH	SA	Total
Agency Infrastructure Requirements	8 FTEs in the Department to support planning, data collection, evaluation, training coordination, monitoring, and project management 1 FTE Facility Disaster Operations Manager	388,491	360,276	748,767
STATEWIDE SERVICE AND SYSTEMIC ENHANCEMENTS TOTAL		$ 31,494,298	$ 18,650,205	$ 50,144,503
NORTHERN VIRGINIA RESPONSE REQUESTS		$ 2,703,072	$ 988,183	$ 3,691,255
GRAND TOTAL		$ 34,197,370	$ 19,638,388	$ 53,835,758

Appendix I
Glossary of Department and Services System Terms and Acronyms

Acronym/Term	Name
AA	Alcoholics Anonymous
AAMR	American Association on Mental Retardation
ABM	Activity Based Management
ABS	Adaptive Behavior Scale (MR)
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act (U.S.)
ADA	Assistant Director Administrative (State Facility)
ADC	Average Daily Census
ADRDA	Alzheimer=s Disease and Related Disorders Association
ADSCAP	AIDS Control and Prevention Project
AHCPR	Agency for Health Care Policy and Research
ALF	Assisted Living Facility (formerly Adult Care Residence)
ALOS	Average Length of Stay
AMA	Against Medical Advice
AOD	Alcohol and Other Drugs
AODA	Alcohol and Other Drug Abuse
APA	American Psychiatric Association
APA	American Psychological Association
Arc of Virginia	Association for Retarded Citizens of Virginia
ARR	Annual Resident Review
ASAM	American Society of Addiction Medicine
ASI	Alcohol Severity Index
ATOD	Alcohol, Tobacco and Other Drugs
ATTC	Mid-Atlantic Addiction Transfer Center
AWOP	Absent Without Permission
BHA	Behavioral Health Authority
C&A	Child and Adolescent
CAFAS	Child and Adolescent Functional Assessment Scale
CAMI	Chemically Addicted/Mentally Ill (dual diagnosis)
CARF	Commission on Accreditation of Rehabilitation Facilities
CASSP	Child and Adolescent Service Systems Program
CCCA	Commonwealth Center for Children and Adolescents (formerly DeJarnette Center) (located in Staunton)
CH	Catawba Hospital (located near Salem)
CHAP	Child Health Assistance Program
CHRIS	Comprehensive Human Rights Information System (DMHMRSAS)
CLAS	Culturally and Linguistically Appropriate Services (standards)
CM	Case Management
CMHS	Center for Mental Health Services (U.S.)

CMS	Centers for Medicare and Medicaid Services (U.S.) (formerly Health Care Financing Administration)
CO	Central Office (DMHMRSAS)
Coalition	Coalition for Mentally Disabled Citizens of Virginia
COBRA	Comprehensive Omnibus Budget Reconciliation Act (also OBRA)
CODIE	Central Office Data and Information Exchange (DMHMRSAS Intranet)
COPN	Certificate of Public Need
CPI	Consumer Price Index
CPMT	Community Policy and Management Team
CQI	Continuous Quality Improvement
CRF	Classification Rating Form (MH-Adult)
CRIPA	Civil Rights of Institutionalized Persons Act
CSA	Comprehensive Services Act for Troubled Children and Youth
CSAP	Center for Substance Abuse Prevention (U.S.)
CSAT	Center for Substance Abuse Treatment (U.S.)
CSB	Community Services Board
CSH	Central State Hospital (located in Dinwiddie)
CSP	Community Support Program
CSS	Community Support System
CVTC	Central Virginia Training Center (located near Lynchburg)
DAP	Discharge Assistance Project
DARC	Division of Administration and Regulatory Compliance (DMHMRSAS)
DCHVP	Domiciliary Care for the Homeless Veterans Program
DCJS	Department of Criminal Justice Services (Virginia)
DD	Developmentally Disabled or Developmental Disabilities
DDHH	Department for the Deaf and Hard of Hearing (Virginia)
DITS	DRVD Incident Tracking System
DJJ	Department of Juvenile Justice (Virginia)
DFA	Division of Financial Administration (DMHMRSAS)
DFM	Division of Facility Management (DMHMRSAS)
DHCD	Department of Housing and Community Development (Virginia)
DHHS	Department of Health and Human Services (U.S.) (or HHS)
DHQC	Division of Health and Quality Care (DMHMRSAS)
DI	Departmental Instruction
DMAS	Department of Medical Assistance Services (Virginia)
DMHMRSAS	Department of Mental Health, Mental Retardation and Substance Abuse Services (Virginia)
DOC	Department of Corrections (Virginia)
DOE	Department of Education (Virginia)
DOJ	Department of Justice (U.S.)
DP	Division of Programs (DMHMRSAS)
DPSP	Division of Programs for Special Populations (U.S.)
DRGs	Diagnosis-Related Groups
DRS	Department of Rehabilitative Services (Virginia)

DRVD	Department for the Rights of Virginians with Disabilities (Virginia)
DSM-IV	Diagnostic and Statistical Manual (Mental Disorders), Fourth Edition
DVH	Department for the Visually Handicapped (Virginia)
ECA	Epidemiologic Catchment Area
ECO	Emergency Custody Order
EI	Early Intervention
EIA	Early Intervention Assistance
EMTALA	Emergency Medical Treatment and Active Labor Act
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
ESH	Eastern State Hospital (located in Williamsburg)
FAPT	Family Assessment and Planning Team
FAS	Fetal Alcohol Syndrome
FFP	Federal Financial Participation (Medicaid)
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FHA	Federal Housing Administration (U.S.)
FMLA	Family and Medical Leave Act
FMS - II	Financial Management System (DMHMRSAS)
FRP	Forensic Review Panel (DMHMRSAS)
FTE	Full Time Equivalent
GAF	Global Assessment of Functioning
HCB	Home and Community-Based (Medicaid MR Waiver)
HGTC	Hancock Geriatric Treatment Center (at Eastern State Hospital in Williamsburg)
HIE	Homeless Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HJR	House Joint Resolution
HMO	Health Maintenance Organization
HPR	Health Planning Region
HPSA	Health Professional Shortage Area
HRDM	Office of Human Resources Development and Management (DMHMRSAS)
HRIS	Human Resources Information System (DMHMRSAS)
HRSA	Health Resources and Services Administration (U.S.)
HSA	Health Services Area
HUD	Housing and Urban Development (U.S.)
HVAC	Heating, Ventilation, and Air Conditioning
HWDMC	Hiram W. Davis Medical Center (located in Dinwiddie)
I&R	Information and Referral
IAPSRS	International Association of Psychosocial Rehabilitation Services
ICAP	Inventory for Client and Agency Planning (MR)
ICD	International Classification of Diseases
ICES	Integrated Client Events System (DMHMRSAS)
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICT	Intensive Community Treatment

IDEA	Individuals with Disabilities Education Act
ILPPP	University of Virginia Institute of Law, Psychiatry and Public Policy
ISP	Individualized Services Plan
IP	Inpatient
IPA	Independent Practice Association
IQ	Intelligence Quotient
IS	Information Systems
ISN	Integrated Service Network
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCBHC	Joint Commission Behavioral Health Care
JCHC	Joint Commission on Health Care
LEP	Limited English Proficient
LGD	Local Government Department (a type of CSB)
LHRC	Local Human Rights Committee
LOF	Level of Functioning
LOS	Length of Stay
LSC	Life Safety Code
LTC	Long Term Care
MCH	Maternal and Child Health
MCO	Managed Care Organization
MDR	Multidrug-Resistant
Medicaid DSA	Medicaid Disproportionate Share Adjustments
Medicaid DSH	Medicaid Disproportionate Share Hospital
MH	Mental Health
MHA-V	Mental Health Association of Virginia
MHI	Mental Health Institute
MHPC	Mental Health Planning Council
MHPRC	Mental Health Policy Resource Center
MHSIP	Mental Health Statistics Improvement Program
MIC	Maternal and Infant Care
MICA	Mentally Ill/Chemical Abuser (dual diagnosis)
MI/MR	Mentally Ill/Mentally Retarded (dual diagnosis)
MI/SA	Mentally Ill/Substance Abuser (dual diagnosis)
MMWR	Morbidity and Mortality Weekly Report
MR	Mental Retardation
MR/MI	Mentally Retarded/Mentally Ill (dual diagnosis)
MR Waiver	Medicaid Mental Retardation Home and Community-Based Waiver
MUA	Medically Underserved Area
NA	Narcotics Anonymous
NAEH	National Alliance to End Homelessness
NAFARE	National Association for Family Addiction, Research and Education
NAMI	National Alliance for the Mentally Ill

NAMI -VA	National Alliance for the Mentally Ill - Virginia
NAPH	National Association of Public Hospitals
NAPWA	National Association of People with AIDS
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASDDDS	National Association of Directors of Developmental Disabilities Services
NASMHPD	National Association of State Mental Health Program Directors
NASTAD	National Alliance of State and Territorial AIDS Directors
NCADD	National Council on Alcoholism and Drug Dependence
NCADI	National Clearinghouse for Alcohol and Drug Information
NCCAN	National Center on Child Abuse and Neglect
NCH	National Coalition for the Homeless
NCS	National Comorbidity Survey
NF	Nursing Facility
NGF	Non-general Funds
NGRI	Not Guilty by Reason of Insanity
NHCHC	National Health Care for the Homeless Council
NHIS-D	National Health Interview Survey Disability Supplement
NHSDA	National Household Survey on Drug Abuse
NIAAA	National Institute on Alcohol and Alcohol Abuse (U.S.)
NIDA	National Institute on Drug Abuse (U.S.)
NIH	National Institute of Health (U.S.)
NIMH	National Institute on Mental Health (U.S.)
NVMHI	Northern Virginia Mental Health Institute (located in Falls Church)
NVTC	Northern Virginia Training Center (located in Fairfax)
OAE	Office of Architectural and Engineering Services (DMHMRSAS)
OAG	Office of the Attorney General (Virginia)
OAMC	Office of Accreditation and Medical Consultant (DMHMRSAS)
OAS	Office of Administrative Services (DMHMRSAS)
OB	Budget Office (DMHMRSAS)
OBRA	Omnibus Budget Reconciliation Act of 1989
OBS	Organic Brain Syndrome
OCA	Office of Consumer Affairs (DMHMRSAS)
OCAR	Office of Cost Accounting and Reimbursement (DMHMRSAS)
OCC	Office of Community Contracting (DMHMRSAS)
OFRC	Office of Financial Reporting and Compliance (DMHMRSAS)
OFS	Office of Forensic Services (DMHMRSAS)
OFS	Office of Fiscal Services (DMHMRSAS)
OGM	Office of Grant Management (DMHMRSAS)
OHRts	Office of Human Rights (DMHMRSAS)
OIA	Office of Internal Audit (DMHMRSAS)
OIG	Office of the Inspector General (Virginia)
OIM	Office of Investigations Management (DMHMRSAS)

OITS	Office of Information Technology Services (DMHMRSAS)
OL	Office of Licensing (DMHMRSAS)
OLIS	Office of Licensure Information System (DMHMRSAS)
OLPR	Office of Legislation and Public Relations (DMHMRSAS)
OMHRC	Office of Minority Health Resource Center (U.S.)
OMHS	Office of Mental Health Services (DMHMRSAS)
OMRS	Office of Mental Retardation Services (DMHMRSAS)
ONAP	Office of National AIDS Policy (U.S.)
OPD	Office of Planning and Development (DMHMRSAS)
ORE	Office of Research and Evaluation (DMHMRSAS)
OQI	Office of Quality Improvement (DMHMRSAS)
OQM	Office of Quality Management (DMHMRSAS)
OP	Outpatient
ORLA	Office of Risk and Liability Affairs (DMHMRSAS)
OSAS	Office of Substance Abuse Services (DMHMRSAS)
OSHY	Outreach Services for Homeless Youth
OT	Occupational Therapy
OUR	Office of Utilization Management (DMHMRSAS)
PACCT	Parents and Children Coping Together
PACT	Programs of Assertive Community Treatment
PAIMI	Protection and Advocacy for Individuals with Mental Illnesses Act
PAIR	Parents and Associates for the Institutionalized Retarded
PASARR	Pre-Admission Screening/Annual Resident Review
PATH	Projects for Assistance in Transition from Homelessness (federal grant)
PBPS	Performance-Based Prevention System
PEATC	Parent Educational Advocacy Training Center
PGH	Piedmont Geriatric Hospital (located in Burkeville)
PHA	Public Health Association
PHS	Public Health Service (U.S.)
PKI	Public Key Infrastructure
PL	Public Law (U.S.)
PMPM	Per Member Per Month
POIS	Purchase of Individualized Services
POMS	Performance and Outcomes Measurement System (DMHMRSAS)
Pony Walls	Half-Height Walls in State Facility Patient Living Areas
POS	Purchase of Services
PPAC	Prevention and Promotion Advisory Council
PPC	Patient Placement Criteria
PPO	Preferred Provider Organization
PPW	Pregnant and Postpartum Women
PRAIS	Patient Resident Automated Information System (DMHMRSAS)
PRC	Perinatal Resource Center

PRWOA	Personal Responsibility and Work Opportunity Act of 1996
PSR	Psychosocial Rehabilitation
PT	Physical Therapy
PTSD	Post Traumatic Stress Disorder
PWA	Persons with AIDS
QA	Quality Assurance
QI	Quality Improvement
QMHP	Qualified Mental Health Professional
QMRP	Quality Mental Retardation Profession
Region I	Northwest Virginia
Region II	Northern Virginia
Region III	Southwestern Virginia
Region IV	Central Virginia
Region V	Eastern Virginia
RM	Risk Management
SA	Substance Abuse
SAARA	Substance Abuse and Addiction Recovery Alliance
S+C	Shelter Plus Care
SACAVA	Substance Abuse Certification Alliance of Virginia
SAMHSA	Substance Abuse and Mental Health Services Administration (U.S.)
SANAP	Substance Abuse Needs Assessment Project
SAPT	Substance Abuse Prevention and Treatment (Block Grant)
SARPOS	Substance Abuse Residential Purchase of Services
SATOE	Substance Abuse Treatment Outcome Evaluation
SEC	State Executive Council (of Comprehensive Services Act ACSA@)
SED	Serious Emotional Disturbance
SEVTC	Southeastern Virginia Training Center (located in Chesapeake)
SGF	State General Funds
SHRC	State Human Rights Committee
SJR	Senate Joint Resolution
SMHA	State Mental Health Authority
SMI	Serious Mental Illness
SMSA	Standard Metropolitan Statistical Area
SNF	Skilled Nursing Facility
SPMI	Serious and Persistent Mental Illness
SPO	State Plan Option (Medicaid)
SRO	Single Room Occupancy
SSA	Social Security Administration (U.S.)
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
State Board	State Mental Health, Mental Retardation and Substance Abuse Services Board
STD	Sexually Transmitted Disease

SVMHI	Southern Virginia Mental Health Institute (located in Danville)
SVP	Sexually Violent Predator
SVTC	Southside Virginia Training Center (located in Dinwiddie)
SWVBHB	Southwest Virginia Behavioral Health Board
SWVMHI	Southwestern Virginia Mental Health Institute (located in Marion)
SWVTC	Southwestern Virginia Training Center (located in Hillsville)
TANF	Temporary Assistance for Needy Families (federal block grant)
TB	Tuberculosis
TBI	Traumatic Brain Injury
TC	Training Center
TDO	Temporary Detention Order
TIP	Treatment Improvement Protocols (CSAT)
TQI	Total Quality Improvement
TQM	Total Quality Management
TWWIIA	Ticket to Work and Work Incentives Act of 1999
UAI	Uniform Assessment Instrument
UM	Utilization Management
UR	Utilization Review
URICA	University of Rhode Island Change Assessment Instrument
VACSB	Virginia Association of Community Services Boards
VACO	Virginia Association of Counties
VADAC	Virginia Association of Drug and Alcohol Abuse Counselors
VADAP	Virginia Association of Drug and Alcohol Programs
VAHA	Virginia Adult Home Association
VAHMO	Virginia Association of Health Maintenance Organizations
VALHSO	Virginia Association of Local Human Services Officials
VANHA	Virginia Association of Nonprofit Homes for the Aging
VASAP	Virginia Alcohol Safety Action Program (Commission on)
VASH	Veterans Administration Supported Housing
VATTC	Virginia Addictions Technology Transfer Center
VCAT	Virginia Council on Assistive Technology
VDMDA	Virginia Depressive and Manic-Depressive Association
VEC	Virginia Employment Commission (Virginia)
VHHA	Virginia Hospital and Healthcare Association
VHCA	Virginia Health Care Association
VICH	Virginia Interagency Council on Homelessness
VIPACT	Virginia Institute for Professional Addictions Counselor Training
VML	Virginia Municipal League
VPN	Virtual Private Network
VR	Vocational Rehabilitation
WSH	Western State Hospital (located in Staunton)

Appendix J
Listing of Comprehensive State Plan 2002-2008 Reference Documents

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